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ADDRESS.

PRESIDENTIAL ADDRESS.

Delivered before the Kentucky State Medical Society at its Thirty-Fourth Annual Session, held in Richmond, May 8, 9, and 10, 1889.

BY L. S. McMURTRY, A.M., M.D.

Fellow-Members of the Kentucky State Medical Society.—Thirty-eight years have elapsed since a convention of Physicians of Kentucky was held in the Senate-Chamber at Frankfort, to consider the necessity of organizing a State Medical Society. In effecting permanent organization, the constitution, which was a model of simplicity and conciseness, declared the purposes of the organization in this language:

"First. The cultivation and advancement of medical science and literature by the collection, diffusion, interchange, presentation, and general circulation of medical knowledge throughout the State.

"Second. The establishment and maintenance of union, harmony, and good government among its members, thereby promoting the character and usefulness of the profession."

In October, 1852, the second annual meeting of the society was held in the circuit-court room in Louisville, when the real work of the society was inaugurated. At this meeting the original members were nineteen in number, and included the familiar and memorable names of Breckinridge, Chipley, Dudley, Flint, Foree, Gross, Miller, Letcher, Richardson, Sutton, Sneed, and Spillman. Forty-six physicians were added to the membership at this meeting, among others the names of Bell, Caldwell, Ewing, Hewitt, L. P. Yandell, Lewis Rogers, Powell, Bartlett, Wible, Peter, and Bullitt are found, names familiar to Kentucky people and to students of medical science.

At this meeting Professor Henry Miller made a report on the progress of Obstetrics, a duty for which his original work and superior knowledge eminently fitted him; and Professor Gross read his famous report on Kentucky Surgery. Dr. W. S. Chipley contributed a report on Vital Statistics, in which he gave an exhaustive report of the sanitary condition of the State, illustrated by a valuable map prepared under his direction, the result of a sanitary survey of the State. The counties are arranged in colors with reference to their mortality and the prevalence of disease. Dr. C. H. Spillman, of Harrodsburg, who is still among us respected and honored, made an elaborate report on the Indigenous Botany of Kentucky. The first volume of Transactions was indeed a valuable contribution to medical science and literature. The work done at this meeting demonstrated the facts: First, that an organization for promoting the science of medicine and improving the sanitary condition of our people was needed; second, that the profession in Kentucky was thoroughly imbued with the scientific spirit, and in ability, culture and attainments conspicuously in advance of the age.

Briefly and imperfectly I have sketched the origin and foundation of the society which has assembled here this evening in its 34th annual session. At the time to which I have referred—1852—there were 982,405 inhabitants in the State of Kentucky, and 1,470 physicians. In Lexington, afterward removed to Louisville, a centre of medical education had already been established, drawing to its instructions large numbers of pupils from the great domain west and south of the Alleghanies. The fame of McDowell, Dudley, Drake, Caldwell, Gross and their colleagues had already extended far and near. These were the surroundings and the fields in which our predecessors labored. And now that thirty-eight years have elapsed, with regular annual meetings, save during the four years of civil war, may we not pertinently inquire, what has been accomplished? How can we of the present, best discharge the duty committed to us by our predecessors? What of the future? These are questions which well deserve our thoughtful consideration.

As has already been stated the original constitution declares the chief and first purpose of this organization to be "the cultivation and advancement of medical science and literature, by the collection, diffusion, interchange, preservation, and general circulation of medical knowledge throughout the State." The earnestness of this purpose was attested in 1852 by the historic papers already mentioned, which may be found in the first volume of our Transactions. The time at my command will

not permit even an enumeration of the many important contributions to medical science and literature made through the medium of this society and published in the Transactions through all these years. Elaborate researches and clinical studies bearing upon the various departments of pathology, surgery, and midwifery constitute the major portion of the Transactions. Through the several standing and special committees all the great advances in medical science and every improvement in the art of medicine and surgery have been quickly brought to the attention of the society. Papers bearing upon improvements in medical education have found a place almost every year, and questions relating to Sanitary Science have been a conspicuous feature of our proceedings. By oft-repeated suggestion and indefatigable labor through appropriate committees, the act of the General Assembly establishing the State Board of Health was secured, more recently by the exertion of the able and efficient executive officer of the Board of Health, with the active coöperation of this society, our legislature was brought to realize the importance of further protecting the public health, and passed a law regulating the practice of medicine in this Commonwealth. The custom of holding the annual meetings at various points in the State, observed since the foundation of the society, has of itself promoted the declared purpose of the society by awaking the profession's interest in scientific work and diffusing knowledge. By this means too, county medical societies have been developed and encouraged.

The second purpose enunciated in the constitution relates to elevating the character of the profession. Through this society, from its foundation to the present time, appeals have been constantly made for elevating the standard of professional rectitude, and exposing the evils of charlatanry.

If time and patience permitted, I might enumerate many of the indirect influences exerted by this society in diffusing knowledge, improving the resources of our art, and advancing the public welfare. The charitable institutions of our State have at all times elicited the interest of our society. Our delegates have annually occupied their places in the American Medical Association, and contributed liberally to its proceedings.

From what I have stated relative to the status of the profession in Kentucky at the time this body was organized, it is seen that the standard of Kentucky medicine was conspicuously high. The metropolis of the State has continued to be, and is now, a centre of medical education for the south-west. The medical periodicals edited and published in Kentucky are numerous and of a high order of scientific merit. To these the members of this society have been constant contributors. In 1879 it was decided by the society that its papers and proceedings could be best disseminated through the medical journals of the State, and the annual volume of Transactions was discontinued. The last volume published by the society was the McDowell Memorial volume, containing the oration of Professor Gross and other papers incident to the dedication of the McDowell monument which was erected by the society in Danville in 1879.

An examination of the series of volumes entitled the "Transactions of the Kentucky State Medical Society" enables one to trace the progress of medicine through these years of activity in every department of our art. As knowledge grew apace, and concentration of energy with the necessary division of labor obtained, specialists in medical practice were developed. These gentlemen representing the various specialties, have been for years past the most active and valued contributors to the work of the annual sessions. At the same time the great body of the society is composed of general practitioners, whose studies and observations in general medicine and surgery compose the greater portion of our proceedings and are equally instructive and valuable. Indeed, here, as elsewhere in our profession, many of the most important and original contributions to medical science have emanated from the practical country doctor. So it obtains that the specialist brings here the results of his expert training and concentrated labor to enrich the knowledge of the general practitioner; while the general practitioner strengthens and enlarges the specialist's knowledge in those lines wherein his work began, and with which his special work is of necessity closely related. In thus glancing hastily back over the thirty-three annual meetings, it is not my purpose to present an optimistic view of our society's labors and their results. Perfection is seldom attained in human institutions or human efforts. There are many features of our annual meetings which could be improved. Each year witnesses improvement in some part of our exercises. This is probably most notable of late in the large number of papers presented at the meetings, in the discussions arranged beforehand by the Secretary, and the improved arrangements for reporting and publishing the papers and discussions.

It would also be unfaithful to the record to depict our society's history as a smooth career of harmonious discussion and unanimity of sentiment, opinion and desire. Numerous breezes and some storms have swept across our floor, but these are necessary to progress, and doubtless purify the atmosphere and encourage wholesome growth.

Our organization has not been without its critics and reformers. They are both within and without. The occasional attendant, who seldom, if ever, contributes a paper or participates in the

discussions, expresses his disapproval of those most active in the society's proceedings, claiming that they monopolize the time of the society; forgetting that the attention of the society can be readily had by himself whenever he chooses, unmindful apparently that the most active members are those who make the society what it is, and extend its usefulness. The reformer often appears upon the floor with resolutions to amend the rules and mode of organization of the society, only to show oftentimes that he has not carefully read our constitution and by-laws. From time to time a momentary enthusiasm appears in the form of a proposition to organize a new State Society upon some ideal basis, forgetting that such institutions are built up through years of steadfast labor, and cannot be created in full vigor in a night; and overlooking the important fact that any suggestions looking to improved efficiency are sure of respectful attention upon this floor. The most certain and the speediest way to improve the efficiency of the society, is to attend the annual meetings, and take part in the discussions. If in 1851 in our sparsely settled State our predecessors realized the necessity of organization for the cultivation of medical science, surely the obligation to enrich and improve the efficiency of that organization is now increased. The population of Kentucky has almost been doubled, the number of physicians greatly increased, and the science and practice of medicine and surgery advanced to a degree of perfection beyond the most sanguine expectations of the past generation. In all departments of our art is to be seen the greatest activity, and never before in the history of medicine was there such a demand upon the physician's powers to keep abreast in the line of advance.

ORIGINAL ARTICLES.

PRIMARY SARCOMA OF THE LUNG.

BY A. F. BOCK, M.D.,
OF ST. LOUIS, MO.

On the 13th of September, 1888, I was called to see Bertha F., æt. 5, of German parentage. Family history exceptionally good, parents strong and healthy. Patient had four sisters and one brother, all healthy. Grandparents still living with the exception of the maternal grandmother, who died about two years ago of chronic senile gangrene. According to the mother's tstaement the child had been ill since about July 20 last, when she was taken with a high fever (105°) and complained of severe pain in her left side; which continued with more or less severity until she died. As the fever yielded to quinine it was no doubt of malarial origin. While under my observation there was no increase of temperature, no cough nor expectoration. The right half of the body was constantly bathed in perspiration, the left always dry. There was very little desire for food, but no difficulty in swallowing. Sleep much disturbed by dyspnœa. Pulse ranged between 95 and 110. Previous to July 20 the child had been enjoying good health with the exception of occasional slight ailments. Inspection showed the left thorax considerably increased in size, the intercostal spaces not flattened but stretched; œdema very slight. No movements of the affected side on inspiration and expiration, but a fulness in the epigastrium as if the diaphragm were thrust downwards and forwards. The superficial veins over the left thorax, face and neck were distended. Emaciation of the whole body very marked. Percussion sound flat over the entire area of left lung. Auscultation of the affected lung showed total silence in regard to respiratory sounds. Heart sounds and beat were to the right of the sternum and below the nipple somewhat accelerated and weak, but otherwise normal. Palpation showed absence of vocal thrill.

The history, symptoms and physical signs in this case coincided so closely with those of empyema that Drs. Mullhall and Ostertag, who were called in consultation, concurred in the opinion that the phenomena which the patient exhibited could only be due to purulent effusion in the pleural cavity. Two days previous to Dr. Mullhall's consultation I introduced a needle in the seventh intercostal space a little in front of the axillary line, drawing only a small quantity of apparently sero-purulent fluid. In order to allay the unmanageable struggles of the child a few whiffs of chloroform were administered, but this was soon abandoned on account of alarming symptoms of heart-failure setting in. No further attempts at tapping were made that day. Two days later, with Drs. Mullhall and Ostertag present two more punctures were made with the same result. As the needle was perfectly movable in the mass, it was thought the contents of the chest were too thick to pass through the needle, and while considering for a moment the propriety of making an incision the child suddenly became cyanotic, struggled for breath, and in less than a quarter of an hour expired, all efforts at resuscitation proving fruitless.

Post-mortem twenty-four hours later. On opening the thorax the heart was found pushed over to the right side beyond the right margin of the sternum; the pericardium contained a small quantity of serum. The entire thoracic cavity of the left side was occupied by a white, moderately soft mass, in which no distinct lung-structure could be seen. The left bronchus was entirely obliterated. The heart, the right lung, the spleen and liver showed no sign of disease or secondary degeneration. The neighboring lymphatic glands were

not enlarged nor otherwise diseased. The tumor was easily removed, as there were no adhesions except a cord-like pedicle about the size of a little finger at the root of the lung, containing the blood-vessels that nourished the tumor. The tumor weighed 3 lbs., 3½ ozs., was 6½ inches long, 7 inches broad and 16½ inches in circumference.

Dr. L. Bremer, of this city, to whom the tumor was sent for microscopical examination, made the following report: The tumor is oval-shaped, has the size and form of a human brain minus the cerebellum. A longitudinal median incision makes the resemblance to the two hemispheres a very close one. Its color and consistence is that of brain substance, thus resembling, on coarse inspection, the class of tumors termed encephaloid. Minute examination with the microscope, however, shows that, though a malignant tumor, it is not an encephaloid, if by this name the soft and rapidly growing variety of carcinoma is understood. The surface of the tumor is uneven, recalling the convolutions and depressions of a brain. Sections of its substance reveal in some places a homogeneous white substance; in others it looks marbled, owing to many hæmorrhages which have taken place. These hæmorrhages have also caused many more or less circumscribed softened spots throughout the tumor. An enveloping mass varying between ½ and 1 line in thickness, and of apparently denser consistence, surrounds the tumor and corresponds to the visceral layer of the pleura.

Thin sections of the tumor examined under the microscope show circular and spindle-shaped bodies of considerable size, besides fat globules of variable diameter. Stained with borax carmine and examined in glycerine the spindle cells become more manifest, and it is now clear that the object under examination is a large spindle-celled sarcoma undergoing fatty degeneration. A specimen stained in the same manner but examined after dehydration, in oil of cloves and Canada balsam exhibits large oblong and round nuclei (the latter being the transverse sections of the former) with very little more or less homogeneous or slightly fibrillar basis substance.

Primary spindle-celled sarcomata of the lungs, it seems, are very rare. Other varieties, as carcinomata, adenomata, fibromata, osteomata, and enchondromata, seem to be of somewhat more frequent occurrence as primary tumors of this organ. As a rule, all tumors of the lung are secondary growths. J. S. Billings, Surg. U. S. A., in charge of Library of the Surg.-General's office, Washington, D. C., says: "The only distinctly recognized primary spindle-celled sarcoma of the lung of which I have any note, is that reported by Chiari in the *Wiener Medizinische Presse*, 1878, vol. xix, p. 112. In the 'Transactions of the Pathological Society of London,' vol. ix, 1858, p. 31, Dr. Wilks reports a case of primary tumor of the lung composed of long nucleated fibres lying side by side, which was probably of the same character. Also in the *Revue Médicale de l'Est*, vol. iv, 1875, p. 119, Dr. E. Demange reports a case of primitive sarcoma of the lung with thrombosis of the pulmonary artery. The tissue of the tumor is composed of fusiform cells with long prolongations, forming what he calls a fasciculated sarcoma, which I take to be the same thing as the spindle-celled sarcoma."

The best authenticated case of primary sarcoma of the lung is that of Dr. L. Ruetimeyer, published in the *Schweitzer Aerztl. Correspond. Blatt.*, 1886, No. 7. He too had mistaken the condition for empyema, and it was the dry tapping that led him to suspect a tumor. Only the lower lobe of the left lung, however, was changed into a sarcomatous mass.

To distinguish such tumors of the lung from empyema, for which it seems they are universally mistaken, there is, I believe, no certain sign, except that elicited by the exploring needle, which must, however, not be too small, and must be inserted at various points in the intercostal spaces, and to a considerable depth. The exuding fluid should be subjected to a microscopic examination, which may possibly reveal the nature of the disease. In my case, owing to an accident, a microscopic examination was not made. The diagnosis in these cases may furthermore be facilitated by considering the peculiarly even distension of the thorax, barrel-shaped; the stretched but not bulging intercostal spaces; the passive dilatation of the superficial veins on the affected side; the greater resistance felt by the finger on percussion; and the total absence of respiratory sounds on the affected side.

ON THE MANAGEMENT OF FUNCTIONAL DISORDERS OF THE STOMACH.

Read before the Georgia State Medical Association, at Macon, Ga., April 19, 1889.

BY P. R. CORTELYOU, A.M., M.D.,
OF MARIETTA, GA.

In calling the attention of this Association for a short time to some points "On the Management of Functional Disorders of the Stomach," I am fully aware that the subject is trite, and that nothing especially new can be said in regard to it. That it has been thoroughly written on by able and scholarly minds, and that in a manner so fully that it would be hard indeed to add even a few threads of purely original thought. My apology, if one be necessary, must be found in this—that it is not the rare and infrequent diseases that most often perplex the daily practitioner, but the more common maladies of every day life, and those which often are considered to be of little special interest;

yet it is often in these very cases that our patients expect and look for speedy relief.

It is not my purpose, nor is it necessary at this time that we should discuss the physiology of gastric digestion, nor the importance of its proper performance, for the securing of good health. Suffice it to say that the stomach is one of the most important, as well as perhaps the most abused organ in the human system. Some ancient solon has said, "Keep the head cool, the feet warm, and the stomach all right, and you will have little need of doctors." However that may be, we know that the condition of the stomach is at the foundation of many diseases.

When we consider what the human stomach has to endure, in receiving into it things hot and cold, raw, boiled, fried, and at all times and hours, from early morn often until the midnight hour, we cannot wonder that it will fail at times to do the work placed upon it.

We are told that Samson, with the jaw-bone of an ass, slew a thousand men, but we think that the hot biscuit and frying pan have slain their tens of thousands.

Among the causes affecting the digestion may be mentioned predisposing and exciting causes. Everything which causes depressed vitality is a predisposing cause to indigestion. It may be caused by hot and debilitating climate, changes in the elementary constituents of the blood, exhausting diseases, mental and moral emotions act as predisposing causes. Age, also, in the extremes of old age and infancy. Anæmia, and deficiency of the gastric juice, are also predisposing causes. The immediate exciting causes are errors in diet, excessive eating and drinking. The use of unwholesome food and such as is not properly prepared. Too frequent introduction of food into the stomach without giving the organ sufficient time for rest, acts as an exciting cause. Also irregularity in eating, and rapid eating, the food not being thoroughly masticated.

In treating these cases all these things must be considered and overcome to effect a cure. In the following reported cases, which have been under my care during the past year, I have adopted a somewhat routine line of treatment, but one that has proven very beneficial, and therefore I report them at this time.

Case 1.—Miss H., single, æt. 35 years. I was called to see the patient October 3, 1887. She gave me the following history. She had been suffering for months with severe pain in the stomach, and severe vomiting, often unable to sleep at night on account of the pain. She had lost a good deal of flesh, and was unable to sit up all day. Could eat no solid food without having pain and distress. There was marked tenderness over the epigastrium. The patient very despondent and apprehensive of cancer. Had used various remedies without receiving benefit. Ordered glass of hot water to be taken one hour before each meal, and pill consisting of arsenious acid $\frac{1}{60}$ grain, extract nux vomica $\frac{1}{8}$ grain, belladonna $\frac{1}{8}$ grain, reduced iron 1 grain, to be taken after each meal. Blister, size of silver dollar, over the epigastrium, and powder of ingluvin 10 grains, before each meal. Diet, milk, some beef essence, boiled rice. October 6. Patient improving, less pain after eating, sleeps better at night. Ordered bismuth subnit. 4 grains, pulv. pepsin 4 grains, pulv. ipecac grain $\frac{1}{2}$, before each meal, in place of ingluvin. The pills and hot water continued. October 10. Patient still improving. Bowels costive. Ordered fld. ext. cascara sag. 20 to 30 drops at night. I increased diet, giving stale, light bread, crackers, soft boiled egg. Patient able to get out of doors when pleasant. From this date she steadily improved, until she fully regained her strength and was able to take regular diet, her friends telling her she had not looked so well for years, and she still continues to keep well.

Case 2.—Judge C., æt. 71. Called to see the patient April 22, 1888. Gave following history: He had suffered from chronic bronchial trouble for years, and has been spending the winters in Georgia and Florida. He had just come from Florida and was suffering with severe cough, just recovering from an acute attack of bronchitis. His stomach was very tender on pressure, and he was unable to take food without pain and distress, and nausea. Ordered quieting mixture for the cough. Glass of hot water one hour before each meal. with elix. lactopeptine after each meal, and small blister over the epigastrium. Diet: milk, beef essence, crackers, and stale bread. Patient improved rapidly under this treatment, the hot water having a very beneficial effect on his stomach. In about ten days he was able to take regular diet with appetite and without distress.

Case 3.—Miss B., æt. 40. Called to see patient July 1, 1888. She gave following history: For several weeks had been suffering with severe pain and distress on taking food, and with severe choking spells. Complains of burning and boring pains in the stomach, and tenderness on pressure. Much emaciated, unable to sleep, pale and nervous, anæmic and despondent. Had been under treatment, but received no benefit. Ordered glass of hot water one hour before each meal, small blister over the epigastrium, and powder of bismuth and pepsin, 5 grains each, after meals; aromat. spts. of ammonia, Hoffman's anodyne, and spts. lavender Co., for choking spells. Diet: milk and lime water, stale bread and some chicken broth. July 9th. Patient improving, but still complains of pain in the stomach, but not so constant. Ordered powder of $\frac{1}{4}$ gr. calomel, $\frac{1}{15}$ gr. morph. sulph., 5 grains bismuth subnit, after each meal. Patient improved steadily on this treatment with the hot water; increased diet, giving soft boiled

eggs, soft boiled rice, tea, soda crackers. July 31, 1888. Patient gaining in strength and color and flesh, has very little pain after eating. Ordered pill of $\frac{1}{10}$ grain arsenious acid, $\frac{1}{4}$ grain ext. nux vomica, and 1 grain each of quinine and reduced iron, after each meal. From this date patient steadily improved, and returned to her regular diet, and had no further trouble.

Case 4.—Mrs. M., colored, æt. 35. I was consulted by patient July 31, 1888. She gave the following history: Had been for weeks suffering with severe pain in stomach and left side; unable to take food without pain. Had been under treatment, but received no benefit. Ordered glass of hot water one hour before each meal, fly blister over stomach, powder of bismuth and pepsin, 4 grains each, after meals. Diet: milk and lime water, stale bread, and soft boiled rice. Patient improved rapidly on this line of treatment. August 9th. Patient able to take food without pain or distress. Ordered mixture of nux vomica, bismuth and carbolic acid, after each meal, and from this time she has had no further need of treatment.

Case 5.—Mr. A., æt. 35, married. Called to see patient November 29, 1888. He gave the following history: For about one year had been suffering from severe attacks of pain in stomach and bowels, which unfitted him from attending to his business, and frequently prevented sleep. Had lost considerable flesh and was very despondent. Had been under various lines of treatment, but received no permanent relief. His skin was sallow, tongue coated with white fur, bowels costive, tenderness over the epigastrium and liver. Ordered glass of hot water one hour before each meal, small blister over the epigastrium, mild laxative for constipation, and mixture of acid nitro hydrochl., dil., ℥iss, syr. sarsaparilla co. ℥ij; one teaspoonful to be taken after each meal. Diet: milk and lime water, beef essence, stale bread and soft boiled rice. On this line of treatment patient continued to improve and was relieved of pain and distress, gradually became able to take fuller diet, and gained in strength and flesh. April 1, 1889. The patient has been at work during the winter, has gained 15 pounds in flesh and able to take his regular meals without trouble, but still using the hot water once a day and the nitro. hydchl. pil. occasionally.

From the results obtained in these cases, with others not reported, I have been led to feel that in hot water, properly used, we have a very beneficial agent in all catarrhal conditions of the stomach, and one that is generally grateful to the patient. I have also found the use of small fly blister over the stomach to aid in relieving nausea and pain and tenderness, and think that these means, together with proper regulation of diet, will be successful in relieving many of these distressing and troublesome disorders of the stomach, which are functional.

UNCOMPLETED NEPHRECTOMY.

CALCAREOUS VESSEL MISTAKEN FOR A CALCULUS BY THE NEEDLE TEST—OPERATION ABANDONED ON ACCOUNT OF ADHESIONS—DEATH—AUTOPSY—PRIMARY ENCEPHALOID OF THE KIDNEY.

Read at the Regular Meeting of the Philadelphia County Medical Society, March 27, 1889.

BY W. W. KEEN, M.D.,

PROFESSOR OF SURGERY IN THE WOMAN'S MEDICAL COLLEGE OF PHILADELPHIA.

G. M. C., æt. 68, weight 164 pounds, 6 feet 2 inches tall, was sent to me through the kindness of Dr. E. W. Watson, on October 31, 1888, with the following history:

On April 6, 1886, he had an attack of retention of urine. Violent expulsive efforts forced out a clot. The bleeding continued two or three days. With this he had pain in the right lumbar region. A month later another similar attack occurred, the pain on this occasion being quite severe and amounting to a distinct renal colic. Other attacks, always accompanied by pain and bleeding, occurred in July, 1886, and in January, September and November, 1887. After the last one, for several weeks he had repeated and nearly continuous hæmaturia with a sensation of heat in the right lumbar region, and he lost strength and appetite.

January 14, 1888, he was taken extremely ill with pleuro-pneumonia and septicæmia. Both legs were attacked with phlegmasia. The dulness in the right kidney, Dr. Watson stated, was increased, but no pus was found in the urine either then or at any other time; neither were any symptoms located in the bladder. This illness lasted about two months.

In May and June of 1888 he again had attacks of hæmaturia, and from September 17 to October 31, 1888, he has had nine attacks, passing as much as six or eight ounces of blood, he thinks, in some of the attacks. He has never passed any calculus. In the interval between the attacks the urine was clear. No cause can be assigned for the attacks; not uncommonly they have come on while he was lying in bed. He states that the right kidney is now the seat of marked aching pain.

Present condition.—He is a very tall man with a disproportionately long chest; from the ribs to the crest of the ilium the space is barely two fingers in breadth. The bladder was sounded but no stone was found. Its walls were rugose. The prostate not much, if at all, enlarged. Renal dulness on the two sides equal and normal. Right kidney tender. Two specimens of urine were furnished, one with a large bloody sediment, but without clots, and the other clear and acid, sp. gr. 1022; very slight amount of albumin. Microscopic examination showed no crystaline elements, a few blood discs, granular matter, and a large number of bright fatty-like small globules. Dr. Watson informed me that he had never

found any albumin except just after the attacks of hæmaturia, nor has he ever seen any cast.

It was decided to explore the right kidney, either for stone or possibly for cancer, and either to remove the stone or the kidney, as might seem best.

Operation, Nov. 3, 1888.—Present, Drs. E. W. Watson, A. W. Watson, W. J. Taylor, and T. R. Neilson. An oblique incision, four inches in length, was made just to the right of the erector spinæ, and the perinephritic fat was reached. Surrounding the kidney was a capsule so loose and distinct that it required a very careful examination to be sure that it was not the wall of the colon. The lower end of the kidney appeared normal. The finger detected a rather sharp irregularity deep in the substance of the kidney. The moment it was pressed on, both Drs. Taylor and Neilson, as well as myself, were convinced that it was a stone. A needle was then passed into the kidney, and the point of it grated with great distinctness against the supposed stone. The kidney was now seized with a volsella, and was loosened from the surrounding tissues in order to obtain freer access to it. This was followed by two results: First, very abundant, indeed very alarming hæmorrhage, from large veins that were so concealed under the last rib that they were seized with great difficulty, even after the rib was well raised, and when seized they were so friable that the ligatures would not hold.

The second result of this operation was to disclose the fact that while the small portion of the kidney first discovered was normal, the rest of it was irregular, nodular, and friable, and evidently the seat of a malignant growth. Accordingly, I determined to remove the kidney, if possible. It was rapidly detached from its capsule by the finger, but it was so anchored internally at the hilum that it could not be brought to the surface, in spite of the fact that I got my entire hand into the cavity of the capsule.

Having proved the impossibility of removing the kidney by the loin, I debated the question of attempting it by an anterior incision, but as the difficulty of removal was not the size of the kidney, but the adhesions at the hilum, I concluded not to attempt an operation by this route, as I felt convinced it would result in the patient's dying upon the table. The hæmorrhage had been exceedingly profuse, not from any one particular vessel, or from rupture of the vessels of the hilum, but from every point in the kidney and in the capsule the moment they were separated. This hæmorrhage was checked by thoroughly packing the wound with sublimate gauze. The patient was put to bed. He became conscious and recognized his family, but died from exhaustion three and a half hours after the operation.

Autopsy, twenty hours after death. In order to determine whether I could have removed the kidney more readily by the anterior incision, I made this attempt as the first step in the autopsy. An incision was made in the right linea semilunaris. This incision measured four inches in length, extending from the border of the ribs to Poupart's ligament. No more room, therefore, was obtained for the removal of the kidney anteriorly than posteriorly. The ribs projected so far downward that, in order to reach the kidney, it was necessary to insert my entire hand up to the wrist. The kidney lay far up under cover of the ribs, and was as inaccessible from the front as from the back. It was so thoroughly anchored in its position that to loosen it from its bed required force that would have been wholly unjustifiable during an operation, and would have resulted in rupture of the vessels and in immediately fatal hæmorrhage. It would not have been possible to reach and tie the vessels in such an inaccessible position. When removed, the kidney was found to be enlarged, nodular, and distinctly cancerous. The left kidney and other abdominal viscera were normal.

On section of the kidney there were discovered some calcareous vessels and one or two points of calcification of the other tissues. The kidney measured seven and a quarter inches in length, four and three-quarter inches in width, and three and one-quarter inches in thickness.

Microscopical examination by Dr. J. P. Crozer Griffith showed that it was an intermediate form between scirrhus and encephaloid, with a decided preponderance in the greater part of the organ of the latter form of the disease.

REMARKS.—*First, diagnosis.*—This lay most likely between stone in the kidney and cancer of the kidney. Although it seemed unlikely that stone should exist without producing pyelitis and, therefore, showing some pus in the urine, yet I have known of more than one case of both stone in the bladder and in the kidney in which the urine contained no pus. The repeated hæmaturia looked very much toward malignant disease, but the kidney was so under shelter of the ribs that it was impossible to detect any tumor, and the dulness was not markedly increased. The enlargement of the kidney was chiefly toward the hilum, and so the dulness posteriorly was little greater than normal. Mr. Henry Morris states that of thirty cases of cancer of the kidney, found in 2,610 autopsies, twenty-five were secondary and only five were primary. The present specimen is undoubtedly a primary malignant tumor, and is, therefore, a rare form of disease.

Secondly, the surgical aspect of the case.—In this there are two points of interest: First, the needle test for stone. When the kidney was exposed to view, the only healthy portion of it remaining was first seen. Deep under this an irregular, hard mass could be felt, which might easily be a

stone. Puncture by the needle convinced us that it was such. Examination of the kidney after death showed us that no stone existed, but that what was felt by the point of the needle was either a calcareous vessel or a calcareous degenerative mass against which the point of the needle grated. It gave precisely the same sensation as a stone would have done. This possible error seems to me very unusual. I have never seen it noticed, although it may have escaped my knowledge.

Secondly, the advantages of the lumbar or of the abdominal route for removal. As the operation was undertaken primarily for exploration, and no tumor in any sense was discovered, I am clearly of opinion that the lumbar route was the proper one to select. The attempt made at the autopsy shows that the kidney could not have been removed any more readily by the abdominal than by the lumbar incision. The peculiar situation of the mass in question, and the low position of the ribs, resulted in the curious fact that while the space between the last rib and the crest of the ilium was only two fingers in breadth, yet the oblique incision here of four inches was long enough for removal, and it could have been still further prolonged anteriorly if necessary; whereas, the vertical incision from the rib to Poupart's ligament was absolutely limited to four inches, and the kidney was certainly no more accessible by this route than by the other. The removal of the kidney was practically impossible by either method. The inflammatory attachments—especially around the hilum and the great vessels of the kidney—required an amount of force that would have been unjustifiable during life.

LIGATION OF SPLENIC ARTERY FOR CURE OF HYPERTROPHY OF SPLEEN.

A Paper read before the Wayne County Medical Society, May 2, 1889.

BY HAL C. WYMAN, M.D.,

PROFESSOR OF PRINCIPLES OF SURGERY, MICHIGAN COLLEGE OF MEDICINE AND SURGERY, DETROIT.

An Italian, æt. 45 years, who had lived in America and the valley of the great lakes for five years, was brought to the Emergency Hospital with a tumor occupying the left abdominal cavity. His history showed that he had had repeated attacks of malarial fever, which had been treated with quinine. Three years ago he first noticed the tumor in the abdomen, and found himself growing weaker than the previous attacks of ague accounted for. For about a year he had been unable to work owing to the shortness of breath caused by the pressure of the tumor on the diaphragm. He had been constantly under medical care. Had had mercurial and iodine ointments rubbed over the tumor, had taken medical treatment from quacks as well as regulars, but steadily grown worse. He solicited an operation. I examined some of his blood taken from his gums, and could detect no want of proper relation existing between the white and red corpuscles.

I made a careful surgical survey of his case. Found the tumor an enlarged spleen, the hilum of which could be felt as a notch 1 inch to the right and below the umbilicus. His skin was tawny but natural in color. His urine was normal. His stools were infrequent, very hard and dry. His heart and respiration normal, so far as physical signs were able to detect their functions. The lymphatics were not enlarged.

The tumor was immovable, adherent apparently to the abdominal parietes beneath the ribs and along the left side. He said his strength was steadily failing, that he could not breathe much longer unless the tumor was taken away. I determined to operate. I had little hope of removing the spleen, so firm were its adhesions, but I hoped to bring about its atrophy by starving it. In the presence of the students of the Michigan College of Medicine and Surgery, and a number of professional friends, I opened the abdomen in the linea alba. The wound oozed freely, but hot water sponging checked it. The omentum was found very adherent. The spleen was adherent to a part of the intestine, omentum and abdominal wall. Carefully I made my way to the hilum of the spleen and, isolating two branches of the splenic artery as they entered the organ, ligated them with carbolized silk. Some hæmorrhage ensued, but hot sponges checked it. The abdominal wound was closed and dressed antiseptically. The patient suffered greatly from shock, but rallied after about twelve hours. Twenty-four hours after the operation he began to vomit and his temperature rose to 104°, with small pulse. Vomiting soon became severe, and collapse, preceded by acute peritonitis, closed the scene forty-eight hours after the operation. No autopsy was permitted, but the tumor shrunk remarkably as a result of the ligation of the arteries. I was led to perform this operation as a result of a series of surgical studies of the consequences of ligation of the splenic artery and its branches in dogs. Ligation of the common splenic artery of the dog was followed by death, and the autopsy showed an acute necrosis of the spleen. Ligation of two branches of the artery which supply blood to about one-third of the spleen caused, in most instances, a progressive atrophy of that part of the spleen deprived of its arterial blood. The dead spleen pulp, when injected beneath the skin of rabbits, caused death after twenty-four hours with symptoms of acute sepsis, suggesting the idea that the spleen is a place for the physiological metamorphosis of septic materials, and that the organ enlarges after malarial poisoning in the

endeavor to perform its functions. The other ductless glands may assist in this labor, and be able to perform the functions of the spleen when that organ is overworked or has been removed from the system.

REPORTS FROM HOSPITALS.

SURGICAL CLINICS AT THE WESTERN PENNSYLVANIA HOSPITAL BEFORE THE STUDENTS OF THE WESTERN PENNSYLVANIA MEDICAL COLLEGE.

BY PROFESSOR J. B. MURDOCH,

SURGEON TO THE WESTERN PENNSYLVANIA HOSPITAL AND PROFESSOR OF CLINICAL SURGERY IN THE WESTERN PENNSYLVANIA MEDICAL COLLEGE.

[Reported by WILL. N. PRINGLE, M.D., a member of the Graduating Class.]

December 8, 1888.

OPERATION ON A CRUSHED HAND.

The case which we will show you first today is one of those very frequent accidents that we see, namely, a railroad crush. This young man was following his occupation as a railroad brakeman, last Sunday, six days ago, when he had his hand crushed in the terrible manner which you see. He was brought here, but he stoutly objected to an amputation, and his father, who was with him, also refused to give his consent to an operation. He has, however, seen the error of his way, and now wants an operation done, and an operation that should have been done six days ago will be done now.

Amputations are divided into three periods in regard to the time of their performance, namely: the primary, the secondary, and the intermediate. In cases where a limb is hopelessly lost, all authorities now agree that the sooner it is removed the better. In these cases, in this institution, we operate at once, just as soon as the patient comes under our care; provided, of course, that he is not in profound shock, and not actually dying. And, by carefully examining the statistics of the hospital for the last twenty years, we find that the mortality is wonderfully decreased by so doing. And just here let me say, that the comparison of the records of other hospitals with the records of this hospital shows that more amputations are done here, than are done in any other hospital in the United States; and further, that, according to the number of patients treated, more amputations are done in the Western Pennsylvania Hospital than are done in any other hospital in the world. This statement is the result of careful researches and examination of records and statistics of this and other countries.

Now, in cases of accidents, the question you will often be called upon to decide will be, "Is amputation required or not?" While we try to practice conservative surgery here, and try to teach you conservative surgery, we desire to teach you that *intelligent* or *practical* conservatism which is such a priceless boon to him who possesses it. To illustrate, you see the middle finger of this crushed hand. Although the bones are not broken, the soft parts are contused and lacerated almost its entire length. One kind of conservatism might save that finger. The man would be compelled to remain in the hospital for six weeks, then carry it in a sling for six months, and at the end of that time have a stiff, crooked, useless member, which would continually interfere with the performance of his duty, and perhaps in one year he would come back that we might remove the unsightly, useless member. This is not the conservatism that we would teach you. A member that is preserved merely to hang to the body of the patient as a useless, unsightly encumbrance, and to interfere continually with the proper performance of his duties, or station in life, does not exhibit the practice of true conservative surgery. I will remove the index and middle fingers of this hand at the metacarpo-phalangeal articulation, and in order to get skin enough to make good flaps, will saw off the head of the metacarpal bones. This will leave the man a reasonably useful hand, because he has his thumb remaining, as well as his fourth and fifth fingers. I think that the loss of a thumb is almost equivalent to the loss of a leg, because the remaining fingers having no opponent, are thereby rendered almost useless also. This hand will be dressed in the usual manner, with antiseptic dressing, and we may bring him before you again.

EXCISION OF THE METATARSAL BONE.

We have another case here which will serve as an example, and a warning in regard to the care of the feet. This old gentleman is an Irishman 65 years old, a daily laborer, and resides in that odorous as well as historic locality known as "The Point," and within a short distance of old Fort Duquesne. He was a gay young man at one time, fond of dancing and of wearing tight shoes; and as a result we see such a deformity of his feet as it is but rarely our privilege to behold. His great toe lies almost transversely across the second and third toes, and these, together with the fourth toe, are all dislocated at their metatarso-phalangeal articulation. The elastic spring of the foot is lost, and he walks on the base of the phalanges, over the site of which bunions have formed, which have become so painful that he can only walk with great pain and difficulty. In buying a shoe, the sole should be at least as wide as that of the foot. It seems that people will subject their feet to more pain and agony, for sweet vanity's sake, than they will any other part of

their bodies. It is no rare thing to see women especially with narrow heels on their shoes, 2 inches high, not under the heel of their foot, but under the middle of their foot, and their toes all cramped down into the point of a narrow shoe, causing corns, bunions, warts and deformities, and not unfrequently dislocating the tendon of the tibialis posticus muscle where it passes behind the malleolus; and not only all of these, but the general health suffers, because they who cannot walk cannot take that exercise so conducive to perfect health.

In recent deformities of this kind, or where the deformity is not great, no operation is required. In these cases Dr. Lewis A. Sayre puts a rubber stall over the toe, and to this attaches a strong piece of elastic rubber, and to this fastens a strip of adhesive plaster. The toe is then brought into line, and the plaster fastened to the heel, thus, through the elastic, keeping up a steady traction on the toe.

Now, we propose to do something to relieve this gay Lothario, and but one choice is left us, namely: excision of the metatarsal bone. There are two ways of doing this, however, One way is to open the joint and excise the head of the bone; the other way is to remove a piece from the shaft of the bone below the joint. I propose to open the joint and excise the head of the bone. There are two incisions that may be made here, a straight or an oval, but, as I think I can expose the head of the bone with considerable ease, I will make a straight incision. After the head of the metatarsal bone is removed and the toe brought into position, the base of the phalanx and the sawn surface of the metatarsal bone will be held in close apposition by wires passed through both bones. I will also excise the head of the second, third and fourth metatarsal bones. By a little attention the foot may now be made to present a reasonably good appearance. It will be retained in as good a position as possible by bandages, and in a few weeks this man will have less distress in walking, although he may still not have a perfect foot.

December 22, 1888.

I will show you first to-day the case in which we excised the head of the metatarsal bones of the first, second and fourth toes, two weeks ago. You remember the great toe lay directly across the ends of the second and third toes, and that the toes were all dislocated at their metatarsophalangeal articulations. You see now that the toes all present a reasonably good appearance, and that the great toe is in a line with the inner border of the foot, as it should be. The original dressing put on this foot was not disturbed till the end of ten days, when it was removed and the condition you see here was presented. There is still a wire suture remaining in the wound, but if the wire does not disturb the man we will not disturb the wire.

OPERATION FOR TUMOR ON THE FACE.

The next case is one of tumor occupying the side of the face, or overlying the parotid gland. This man says that it has been growing for twenty years, but that ten years ago it was removed or partly so, but that it began to grow again, and has continued to increase slowly ever since. You can see the cicatrix where it was opened before. Now, the growths that may occur in this locality are various, as enlarged lymphatic glands, enlarged parotid gland, encysted tumor in the parotid gland—and this latter is what I believe this to be. If this is the case I will not likely be able to remove it whole, as it will likely rupture or tear, and the contents be evacuated. In that case I will make an effort to remove the sac by cutting, dissecting or tearing it out. If I am unable to do this I will simply cut off the outer portion, insert a drainage-tube, and sew it up. In removing tumors it is always well to make a free incision through the skin, in order to give yourself plenty of room, then cut down carefully until you find the capsule and cut through it; however, as I do that in this case, the sac is torn and the contents which consist of a large amount of colored blood plasma. I find that the sac is very intimately attached to the surrounding structures, and that the parotid gland is involved in the mischief. If it were not for the long standing of this growth I would look upon it with suspicion, and as it is I am not satisfied that it is not a malignant growth. We will wash the cavity out with bichloride solution and provide free drainage, and make an effort to convert it into an abscess and prevent its return provided it is not malignant.

It is very unsatisfactory to begin an operation and not be able to finish it. You should never begin an operation with so much determination that you cannot stop, when you find that it is to your patient's detriment that you go any further. This is frequently done by surgeons, especially in laparotomies. They open the abdomen expecting to find a certain tumor, or condition, and failing to find what they expected, they cut, and probe, and search for what they wish to find, until they do irreparable injury to their patients. Always be prepared to end an operation when you find that you can do no more good, however unsatisfactory it may be.

FRACTURE OF THE TIBIA AND FIBULA.

We have here another case, a man with a fracture of the tibia and fibula, at their lower third. You see we have all of the symptoms of fracture here. Now this was done by direct violence (this man was struck with a stone) and is much more dangerous than if it had been done in jumping from a heighth, or any other indirect violence. It requires a much longer time to heal. We had a man in the wards here last summer, who was struck with a brick, and it was six months before

it healed. In cases like this, where there is so little swelling and tumefaction, it has been our practice to incase the limb in a plaster dressing at once, but it has been my fortune to see a good many cases of delayed union follow this practice, so I am beginning to look on it with suspicion. It may be that a sufficient amount of blood is not sent to the part under a plaster dressing, or that this dressing in some other way interferes with perfect union. I am, therefore, inclined to try the other way for awhile in cases of fractured leg from direct violence, or until the same bad results convinces me that the early dressing in plaster is not in some way responsible for the delayed union. This limb will, therefore, not be dressed in plaster for four or five days more. It is now two days since the accident occurred.

OPERATION FOR INJURY TO THE FOOT.

Another case is that of a boy who six months ago fell from a hay-loft, injuring his foot. The leg and knee soon became swollen, and when the swelling subsided the numerous openings you see appeared over the front part of the leg. These openings have a pouting appearance, peculiar to themselves, and they are called "cloacaes," from their fancied resemblance to the anus of the hen, they always lead down to dead bone. As I pass the probe down I come in contact with dead bone at once. You will also notice another defect in this leg, namely, that it is bowed outward. This is caused by the fact that part of the tibia has been lost through necrosis, and the entire weight coming on the fibula, it has given way, or bent from the pressure, causing the bowing of the leg. Now we propose to cut down on the tibia and remove the necrosed bone, and in order to cause the sole of the foot to set flat on the floor we will fracture the fibula, and allow the fragments to overlap each other to a small extent, thus reducing the length of the fibula to that of the tibia. I will make an incision, clear down on to the bone, then with a periosteum elevator, lift up and preserve the periosteum. You see that the tibia is separated at its epiphysis above the ankle, and with very little force I am able to remove a sequestrium about 8 inches long, and almost a perfect mold of the tibia, except where it has been destroyed by the disease. It is the most perfect specimen of sequestrium that I have ever removed from so small a limb. I will pack the cavity with iodoform gauze, and leave the lower one-third of the wound open for the purpose of drainage. The boy, I think, will have a reasonably good limb, although amputation of the limb was at one time considered necessary.

EXTIRPATION OF AN EYEBALL.

January 5, 1889.

I have a patient to-day for whom I will extirpate an eyeball. This, properly, should be done by the ophthalmologist, but as this is an operation which you may all be called upon to perform in your practice, I thought proper to bring the case before you to-day. Besides, if all the accidents to the eyes are given to the oculist, and the gynecologist does all the operations falling within his line, and the genito-urinary specialist is given all cases peculiar to his practice, and all the other specialists get their share, there will be but little left for the general surgeon. I, myself, am a specialist, and my specialty is, as Mr. Wilson once said, the skin, and all it contains. When the eye is hopelessly destroyed it should be removed. Because, in the first place, an artificial eye may be better worn, and in the second place, the inflammation and the pathological changes which are set up, are capable, by sympathetic action, of destroying the sound eye. And although the inflammation may be subdued for the time being, and the useless member allowed to remain, still at any time, and from slight provocation, a new inflammation may be set up and the sound eye be quickly destroyed. This man was struck in the eye by a piece of steel, six years ago, and had his eye destroyed. It did not, however, give him much trouble until within a few days, when a new inflammation attacked it, and which is now slowly invading the other eye. The man has applied to us for relief, and extirpation has been decided upon. In doing this the wire speculum is inserted to hold the lids apart. The conjunctiva is then picked up with a small forcep and cut clear around, near the cornea. The recti muscles are then all divided, as close to the sclerotic as possible, and the eye will then bulge forward. You then use a pair of curved scissors to cut off the optic nerve. Of course, when about to do the operation, you will be careful about the eye you are going to remove. Surgeons have been known to remove the wrong eye. This would be a great mistake. After the recti muscles are all divided you introduce the scissors, closed, and feel for the optic nerve. I prefer to introduce the scissors on the nasal side, as the nerve is nearer that than the other side. When you have found the nerve the scissors are opened sufficiently to grasp the nerve and snip it off, as I do here. After the nerve is divided the oblique muscles still remain, which I will divide close to the sclerotic, when the globe is removed with ease. The eye should, where possible, be removed before the humors are allowed to escape, as it is done with less facility when emptied of its fluid. If there is any bleeding in the wound a little water usually controls it, if not, then a cotton compress held in the socket by a bandage is sufficient to control any hæmorrhage there is likely to be. In about three or four weeks this man can be fitted with an artificial eye. He will for the present be kept quiet and his eye kept bandaged.

AMPUTATION OF THE LEG.

We will next show you a boy for whom I amputated a leg just twenty-four hours ago. There has been some rise of temperature, and some soiling of the dressings, so I will take the dressing down and ascertain, if possible, the cause of this disturbance. As I inserted a rather large drainage tube I will now remove it. I think that by this time the serum is all drained from the wound, so that it will not suffer by the removal of the tube. The wound will then be redressed and not disturbed for two, three, or perhaps for four weeks, unless another rise in temperature should indicate that all is not going on well. A large amount of dressing should be placed over wounds like this, so as to absorb all the fluids that may come from the wound, because the moment that the blood shows itself on the outside of the dressings the danger to septic infection at once begins, as the germs more easily penetrate the dressing. It is for this purpose that we use such large amounts of absorbent cotton. And in regard to bandages let me say here, that the ordinary crinoline bandages are the best for wounds like this. When applied wet they adapt themselves nicely to all inequalities of the surface and when they afterward become dry the sizing which is contained in their meshes acts in a modified degree like the plaster in a plaster dressing, making a firm and altogether very excellent dressing. For fractures where you wish to hold parts in apposition, or where you wish to retain splints, or make pressure, the ordinary unbleached muslin makes better bandages. This wound will now be redressed, antiseptically, much the same as an original wound, with the exception of a drainage-tube, and we anticipate no more trouble from it.

MEDICAL PROGRESS.

AUCUTE GENERAL ŒDEMA OF THE LUNGS.—DR. M. GROSSMANN has made a number of experiments supplementary to a work previously published on "Muscarin-Œdema of the Lungs." Recent investigations treat the subject of acute general œdema of the lungs on a broader basis, inasmuch as they touch not only muscarin œdema of the lungs but also the acute general œdema, originating from certain other especially mechanical influences. In reference to this it is proven that in the dog—not in the rabbit only, as was supposed—an acute general œdema of the lungs is produced by obturation of the left auricle and by squeezing the left ventricle.

The investigations furthermore extended to the nature of the difficulty in breathing, hitherto unknown, which appears in a lung overfilled with blood which transudes readily. It is proven that but secondary importance is to be attributed to the transudation itself, and that the principal obstruction to breathing originates from the rigidity of the lung. The supposition that the capillary ectasy caused by the stopping of the blood produces the obstacle to breathing by diminishing the alveolar space is disproven by the fact that in consequence of the congestion not a diminution but an enlargement of the alveolar space, *i. e.* an enlargement of the lung occurs. The author furthermore mentions experiments which show that transudation artificially produced is not an essential obstacle to breathing, from which he draws the conclusion that no especial significance attaches to transudation as an obstacle to respiration. Supplementary to the theory of muscarin intoxication, his recent experiments show that through this poison not only congestion and œdema but also swelling and rigidity of the lungs and bronchial convulsions are produced.

The author describes the process of acute general œdema of the lungs in this way, that the congestion in the lung, by producing enlargement and rigidity, becomes an obstacle to respiration and causes as a final anatomical result transudation.

The primary cause for congestion of the lungs the author, on the ground of his experiments, finds in a narrowing of space of the left portion of the heart, as opposed to the theory of Cohnheim, Welch, who considered a paralysis of the left side of the heart as the cause of œdema of the lungs.—*Internationale Klinische Rundschau*, 1889, No. 15.

ON THE INFLUENCE OF THE DIFFERENT METHODS OF TREATMENT OF ABDOMINAL TYPHUS IN CHILDREN UPON FLUCTUATIONS OF TEMPERATURE AND BODY-WEIGHT.—DRS. LUMIN O. MEYER, R. PETERS and C. TANNENHÄUSER report a number of cases from the hospital for children of the Prince of Oldenburg, of the years 1875, 76, 77, 84, 85, 86 and 87. Excluded were cases in which the fever lasted only one week, such as originated during the last period, and cases complicated with other diseases. Therapeutic experiments were made—1, with baths of 38° C. to 8 times daily, in temperatures exceeding 30° C.; 2, baths of 33° C. with dashes of 22–18°; 3, 4 to 12 dashes daily; 4, large doses of quinine 0.3 twice or 0.5—1.00 once daily; 5, large doses of quinine simultaneously with antipyrin; 6, antipyrin; 7, quinine an antifebrin; 8, antifebrin; 9, amm. salicylate. To render a comparison possible a series of cases was treated expectatively with acid muriatic. For each individual case the average temperature of 5 to 10 measurements was calculated, and with these figures an ideal curve drawn for each. A comparison of all the curves showed remarkable similarity. All curves descend gradually and in

steps, the temperature reaches its acme on the fourth day, to fall after that, only in the cases observed from the first day of sickness a rapid rise of the temperature was noted in the beginning. The antipyretic methods above mentioned did not alter the temperature curve at all. The weight of the patients was taken from one to seven times a week, the daily loss was figured out in per cent. of the body weight as existing on the day of reception into the hospital; the gain, however, in per cent. of the lowest body weight observed.

Dr. Senetz, of St. Petersburg, declares that the measurement of weight in his cases of abdominal typhus showed that an energetic antipyresis had an effect upon the body weight in so far that its decrease lasted for a longer time, and its increase was slower than with indifferent treatment, that the curve of body weight is one of the most reliable clinical symptoms for judging the course of the disease, and that with an energetic antipyresis the course and reconvalescence are more protracted; in children from 7 to 8 years old the body weight increases much more quickly and a cure ensues sooner than in adults.—*Internationale Klinische Rundschau*, 1889, No. 15.

Resection of the Ensiform Cartilage.—An important paper has recently been presented to the Royal Academy of Medicine and Surgery of Naples by a young surgeon, Dr. Rinonapoli, of Collamele, in the province of Aquila, giving the details of an operation for resection of the ensiform cartilage. Only one such case has been previously recorded—by Linoli, in 1857. A man was injured by a horse rearing and falling back upon him. His chest was violently compressed, and the ensiform cartilage dislocated backwards. The displaced cartilage, by its pressure on the stomach, was productive of very severe gastric disturbance, which at length became so great that not even the smallest quantity of milk could be taken without terrrible pain. The patient rapidly wasted away, and his life was despaired of. Various diagnosis were made, but it was left for Dr. Rinonapoli to discover the true state of affairs. Being convinced of the accuracy of his diagnosis, and fortified by the opinions of two colleagues, Dr. Rinonapoli gained the consent of the patient and his friends to an operation.

The minutest antiseptic precautions (carbolic acid and perchloride of mercury) were observed. An incision six centimetres long was made, the upper third being over the sternum. Dissection was carefully carried down to the peritoneum, which was not opened. The cartilage was separated from the structures enveloping it, and, finally, its attachment to the sternum was divided by passing a probe-pointed bistoury behind and cutting forwards. The wound was carefully cleansed and brought together by sutures. In the course of five weeks the patient had completely recovered. The points of interest connected with the case are: 1. That it is only the second recorded. 2. The peritoneum was not opened. 3. It was undertaken by a young surgeon in a country district in Italy, who, with the assistance of two other country surgeons, carried it through in the most praisworthy manner. Dr. Rinonapoli worthily won his admission to the Royal Academy of Medicine of Naples, for which Professor Fusci stood his sponsor.—*Lancet*, March 16, 1889.

On Cocaine—Epilepsy.—Dr. C. Heimann, of Charlottenburg, reports in the *Deutsche Medicinische Wochenschrift*, the case of a patient in whom after long subcutaneous use of large doses of cocaine (up to 8.0 daily), besides cocaine-paranoyia (repeatedly observed during the past years by the author and others), epileptic convulsions occurred. They closely resembled the classical symptoms of epilepsy, and were accompanied by disturbances of the sensorium, complete numbness, subsequent failure to remember the attack, etc. After stopping the use of the poison the morbid symptoms, hallucinations, perverse sensations, frenzy, etc., disappeared, and the convulsions ceased but recurred always when large doses of that drug was used. Now since no other causative factor for epilepsy existed in the patient, hereditary influences were missing, and convulsive conditions had never before been known to him, the author concludes that in this case epilepsy was caused by the alkaloid. This conclusion is supported by experiments on animals in which epileptic fits also occurred after cocaine.—*Therapeutische Monatshefte*, 1889, No. 4.

On the Washing of the Organism in Intoxications.—Prof. Sanquirico has shown that the fatal consequences of an acute intoxication produced by various substances can be avoided by means of washing the organism as proposed by him and often tested, and that this antitoxic treatment is often more valuable than all other methods used is cases of poisoning. Prof. Sanquirico now describes a modification of his treatment which experimentally has proven perfectly effective. The modification consists in this, that for the poisoned individual he makes use, on the one hand, of the physiological antagonism of a drug capable of fully exerting the latter, and on the other hand of the depurative effect of the washing. With this combined action—which is variously applied in given cases—the author wants to serve a two-fold purpose:

1. To obtain a cure in animals poisoned by a quantity against which either of the two ways alone would be insufficient.

2. To obtain a success also in those cases of poisoning in which the simple washing as well as

also the action of a powerful antidote proved useless.

A long series of tests made by Prof. Sanquirico have established the undoubted efficiency of the combined treatment in cases of acute poisoning. It might, therefore, also be used to advantage in acute intoxications in man.—*Internationale Klinische Rundschau*, 1889, No. 15.

CHLORIDE OF BARIUM IN HEART DISEASE.—According to *Les Nouveaux Rèmedes*, H. A. HAZE prescribed the chloride of barium in seven cases of heart disease (once for an infant 6 years old with lesion of the mitral, once for acute dilatation of the heart, twice for lesions of the aorta and once for lesions of the mitral in an adult, and twice for functional disturbances of the heart). The results obtained were very good. In all cases the drug slackens and regulates the heart-beat, augments the amplitude of the pulsations without producing as pronounced a tension as the finger applied to the artery feels after digitalis. At the same time the pulse is considerably prolonged. No renal troubles. The author administered the drug in a 1 per cent. water solution; 1.50 to 2 gr. of this solution repeated three times daily for children, and 5 gr. two or three times daily for adults. In these doses it may be considered as not toxic. As it is, besides, almost tasteless and inexpensive, and acts as rapidly as digitalis, it is to be supposed that this drug will soon render valuable service in the treatment of heart disease.—*Journal de Médecine de Paris*, 1889, vol. xvi, No. 15.

THE TREATMENT OF ACNE.—DR. ISAAC, assistant to Dr. Lassar's clinic for skin diseases in Berlin, discusses in the *Berliner Klinische Wochenschrift*, No. 3, 1889, acne and its treatment. As an etiological factor in the production of acne, he considers that hereditary peculiarities in the opening of the sebaceous glands may have an influence. In such cases the sebaceous duct is wide and funnel-shaped, offering a nidus for dirt and other septic material. Though such anatomical peculiarities may in exceptional instances predispose to acne, its causes are to be sought for in disturbances of the digestive, circulatory, or of the generative apparatus. The treatment in vogue at Lassar's clinic is the following:

R.	Beta naphthol	10.0.
	Sulph. præcipitat	50.0.
	Saponis virid	
	Vaseline	āā 20.0.

This salve is applied thickly to the affected portion of the skin either by a brush or a spatula, and left *in situ* for from half an hour to an hour. On the following day one notices some desquamation of the epidermis and slight irritation and retraction of the skin. This procedure is repeated every day until desquamation of the entire epidermis has taken place. Should much irritation be produced, the treatment may be temporarily stopped and the affected surface covered with an indifferent powder or with Lassar's paste. For especially stubborn cases the following modification of the ointment may be applied:

R.	Pulv. cretæ albæ	5.0.
	Beta naphthol	
	Camphor	
	Vaseline	āā 10.0.
	Saponis virid	15.0.
	Sulphur præcipitat	50.0.

The addition of the camphor increases the irritative power of the ointment, which in this form should only be left on the skin fifteen minutes.

Another formula which has been found serviceable in the treatment of acne is the following:

R.	Resorcin	
	Zinc oxid	
	Amyli	āā 5.0.
	Vaseline	10.0.

—*Jour. of Cut. and Gen.-Urin. Dis.*, May, 1889.

ON THE INOCULATION OF CARCINOMA UPON ANIMALS.—Although carcinoma is a tumor producing metastases, it has so far been found impossible to inoculate it from men upon animals, or from animals upon animals. Transplantation has been attempted from dogs to dogs, or even to rabbits and guinea-pigs, but these attempts have proven futile. MR. HANAN, of Zurich, succeeded in transferring the carcinoma of a rat affected with papillar cancroide to two animals of the same species. He inoculated these two rats in the tunica vaginalis of the scrotum, which in these animals communicates with the peritoneum. At the end of seven weeks one of the rats died from carcinoma. The entire epiploon was covered with nodosities, some the size of a pea, some smaller. The axillary and inguinal glands were similarly affected. These tumors when examined under the microscope showed the same type of carcinoma as that from which the virus was taken. The autopsy of the second rat was made in the presence of Professor Koch, and disclosed analogous alterations. — *La Sémaine Médicale*, No. 18, 1889.

TREATMENT OF OXYURIS VERMICULARIS.—GUBB, *London Med. Record and Allgem. Med. Centralz*, 1889, No. 16, recommends rectal injections of pure cod liver oil or an emulsion of it with eggs, as reliable and not irritating. Grimaud calls attention to the fact that Lallemand (Montpellier) obtained the most reliable results with natural sulphur waters. He (Grimaud) also had opportunity to convince himself that sulphur water is poisonous for intestinal worms. It may be used internally or per clysma, and the worms will soon disappear without returning.—*Therapeutische Monatshefte*, 1889, No. 4.

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LONDON OFFICE, 57 AND 59 LUDGATE HILL.

SATURDAY, JUNE 1, 1889.

SPECIAL NOTICE.

At the moment of going to press a circular has been received calling attention to the "*American Medical Association Annual*," and seeming to represent the Medical Association, soliciting advertisements.

It is proper to state that THE JOURNAL is the only official organ of the Association, and is alone authorized to receive advertisements in its interest.

The Board of Trustees has full control of THE JOURNAL, and as neither the Board, nor its special Committee on Management, nor its editor has any knowledge on this subject, we are at a loss to know upon what authority such solicitations are made.

It is certainly not the purpose of the Association to be related to advertisers in any other manner, than through its official organ—THE JOURNAL.

DEVENTER'S METHOD OF DELIVERY OF THE AFTER-COMING HEAD.

The utterances of DR. JOHN BARTLETT upon obstetrical topics always deserve and commonly receive close attention. It is the purpose of this note to discuss briefly his last contribution to the art of midwifery, "A Study of Deventer's Method of Delivering of the After-Coming Head."[1]

As interpreted by Dr. Bartlett, Deventer's plan differs in essential points from the procedure in vogue, known as the Smellie-Veit method. The posture of the woman is identical with that commonly assumed at the present day—dorsal decubitus, hips elevated. As soon as the child has passed so far as the base of the thorax, extractive efforts are to be made, in a direction downward and a little backward. When the arms are within reach an examination of their relation to the head should be made. Should their position be favorable, that is, on either side of the head, resting anteriorly to the parietal protuberances, delivery may be at once proceeded with. But if the position be unfavorable it should be corrected, either by adjusting the arm to its proper site, or, in the event of that being impracticable, as in case the extremity were in front of the forehead, or behind the occiput, by bringing it down in accordance with established rules. From the moment that the head enters the pelvis the woman must be earnestly called upon to second the efforts of the accoucheur by bearing down with all her power. After the arrest of the chin at the pelvic floor, pressure should be made over the occipital end of the head as nearly behind the anterior wall of the pelvis as practicable, with the view of causing descent of the occiput, and a relieving extension of the head. In a typical case, the occiput appears under the pelvic arch, and the delivery is accomplished with the chin in forced extension, instead of flexion, while the arms are extended along the sides of the head.

The "particular advantages" of Deventer's plan over the Smellie-Veit method, according to Dr. Bartlett, are:

1. What Barnes might call the decomposition of the wedge of the shoulders; in lieu of the bis-acromial diameter presenting at the superior strait, it is the bis-axillary diameter.

2. The arms extended upon the head bridge over the space between it and the body; thus extended they (*a*) act as fenders for the cord, keeping open channels through which the funis may pass uncompressed; (*b*) they antagonize that spastic contraction of the uterus which, closing in upon the lower circumference of the after-coming head, is one of the causes of fatal delay in delivery in these cases.

[1] "A Study of Deventer's Method of Delivering of the After-Coming Head." Transactions of the International Medical Congress. Ninth Session. Vol. ii, p. 438.

3. By this method the delivery of the after-coming head is very greatly simplified. In the majority of instances it may be unnecessary to interfere with the attitude of the head; Deventer claims that, with few exceptions, the head will "shoot through" both straits easily.

4. The delivery by extension is very much more expeditious than the ordinary method. Precious time is not lost in bringing down the arms, inserting the fingers in the child's mouth, etc. As a consequence, if the experience of Deventer is to be relied upon, it would seem to be safer for the mother, and very much safer for the child, than other methods.

Adequate evidence from clinical observation to support these propositions is not supplied by Dr. Bartlett in this essay. They are conclusions drawn purely from *à priori* considerations and from Deventer's alleged successful treatment of artificial breech presentations.

Dr. J. H. Chew,[2] of Chicago, has written an excellent history of one case of delivery by Deventer's method. As at present informed, this single case constitutes the only example of the procedure in practice that has been recorded within recent years. Charles T. Parkes, of Chicago, George Wheeler Jones, of Danville, Ill., Frank L. Wadsworth, of Chicago, and others, have indeed cited cases in which the method was successfully employed, but, in the absence of exact accounts of the conditions and indications present in such cases, the testimony of these gentlemen cannot be accepted as competent.

In this connection, it may be remarked that Dr. Bartlett's citation of Zweifel's statistics of version is not pertinent. Dr. Bartlett writes: "'According to statistics presented by Zweifel, in 3,475 versions the mortality was 58.9 per cent. Says Deventer: 'If this operation of version and extraction of infants be cautiously and skillfully managed, the infant is not exposed to the danger of death.'" Upon the one hand, Zweifel's[3] statistics, as a reading of the context shows, are drawn from cases in which internal version was performed under all possible indications. In many cases, the infants were dead before the operation was performed. They relate to the prognosis of version, not to the prognosis of extraction. Upon the other hand, no practitioner will accept Deventer's dictum that if his operation of version and extraction be cautiously and skillfully managed, the infant is not exposed to the danger of death. Experience teaches that in version and extraction, no matter how favorable the conditions may be, there is always grave danger of death of the infant.

This misuse of statistics may be allowed to pass as a rhetorical subterfuge—as an example of antithesis—but its bearing on the question under discussion must be absolutely rejected.

The fourth and third propositions, formulated by Dr. Bartlett, cannot be sustained. Note that the propositions are universal, that they include all cases. Now it is an obstetrical axiom, from which no man can withhold assent, that that procedure in these cases is safest for both mother and child that imitate most closely the natural mechanism of labor. The natural mechanism constitutes the most advantageous mode of delivery both with reference to the mother and the child. Neither will any one venture to deny that the natural mechanism of labor is most closely simulated by the Smellie-Veit method. The conclusion is obvious.

The Smellie-Veit method of manual aid, originally proposed by Mauriceau, in 1668, and modified by Lachapelle in 1821, consists first in the liberation of the arms, and secondly in the delivery of the head by flexion of the chin upon the sternum by the finger passed through the mouth to the lower jaw, and by traction applied chiefly to the shoulder through the fingers that fork-like are placed on either side of the neck.

In normal cases of natural or artificial breech presentation—these are included in Dr. Bartlett's proposition—the practice of Deventer's method means as forcibly remarked by Dr. Knox,[4] the production of a malposition and then a hunt for a new method to escape from the difficulty. The second proposition seems too fanciful to analyze critically, while the first is manifestly untrue.

Deventer's method doubtless has its place, and under certain conditions may even come to be the operation of election. Thus Smellie points out cases of dystocia in which the procedure may be useful. He writes: "When the forehead is hindered from coming down into the lower part of the sacrum by an uncommon shape of the head

[2] Transactions of the Chicago Medical Society, December 27, 1888. Supplement to Western Medical Reporter, February, 1889, p. 15.

[3] Lehrbuch d. Geburtshülfe Stuttgart, 1887. Page 612.

[4] Transactions of Chicago Medical Society, loc. cit.

or pelvis, and we cannot extract it by bringing it out with a half-round turn at the os pubis; we must try Deventer's turn in the contrary direction."

ILLINOIS STATE MEDICAL SOCIETY.

The thirty-ninth Annual Meeting of this Society was held in Jacksonville, Ill., May 21, 22 and 23, 1889, and was attended by about 200 members. The season was pleasant, the city beautiful, the accommodations provided by the Committee of Arrangements convenient, and the members engaged harmoniously in the legitimate work of the Society. Reports and papers of interest pertaining to almost every department of the science and art of medicine were read and discussed with profit and with much less waste of time than usual. The meeting was called to order at 10 A.M. Tuesday by the President, Dr. C. W. Earle, of Chicago. In the absence of the Mayor, a brief and appropriate address of welcome was delivered by City Attorney Yates, and was responded to in behalf of the Society by Dr. N. S. Davis, of Chicago. In the evening the members of the Society and a large audience of citizens assembled in the Presbyterian Church to hear the President's Annual Address, and also a most interesting musical and literary entertainment by the pupils of the Illinois Institution for the Education of the Blind. Dr. C. W. Earle, the President, has been the attending physician of the Washingtonian Home of Chicago for many years, and thereby brought in close contact with many thousand inebriates; and his address, which was on the subject of "Inebriety and the Responsibility of Physicians in prescribing Alcoholic Remedies in the Treatment of Disease," was listened to with marked attention. He combated vigorously the doctrine that drunkenness was the result of a primary disease of the brain and nervous system, called *inebriety*, or in any considerable degree derived from hereditary influence. He claimed that three-fourths of those addicted to the use of alcoholic drinks were fully able to reform whenever they choose to make a judicious and earnest effort to do so. He admitted, however, that in one-fourth or perhaps less, the long continued use of alcohol had produced such structural changes as to render them incapable of self-control, and for such the State should provide suitable asylums and legal restraint on the same principles that guide in the control of the insane.

The attention of the Society had been chiefly occupied during the day with the important subjects of Pneumonia and Diphtheria, they being presented both in the report of Dr. C. F. Robinson, of Wyanet, Chairman of the Committee on Practical Medicine, and a paper by Dr. J. A. Baxter, of Astoria, and by Dr. Geo. N. Kreider, of Springfield, in a paper on "Tepid Baths in the Treatment of Pneumonia." These papers and the discussions elicited by them, developed the important fact that in many parts of the State pneumonia had been more prevalent than usual during the months of February, March and April of the present year.

The Society was fully occupied with reports and papers on diseases of children, gynecology and obstetrics during the second day, and was entertained by a complimentary concert given by members of the Faculty of the Illinois Conservatory of Music of Jacksonville, in the evening. On the third day work was commenced at 8:30 A.M. and continued until near 2 P.M., after which the members were taken to the Hospital for the Insane. During the session, the time was occupied closely and profitably in considering the report of the Committee on Surgery, and volunteer papers by Drs. E. Andrews and A. E. Hoadley, of Chicago, and Dr. David Prince, of Jacksonville, and the report of the Committee on Ophthalmology and Otology by Dr. H. M. Starkey, of Chicago, and Dr. A. E. Prince, of Jacksonville.

Throughout the three days' sessions it was generally conceded that the Illinois State Medical Society had enjoyed no more pleasant or profitable meeting during its past history, than the one we have thus briefly outlined.

WAS IT A DECOY OR SILLY "CATCH," OR A REAL ATTEMPT TO GAIN POSSESSION OF A DIPLOMA, IN DUE FORM, UNDER THE PRETENSE OF HAVING IT CONFERRED UPON A "FRIEND?"

The following letter, dated Boston, Mass., April 12, 1889, was addressed to the Dean of the Medical Department of a University located east of the Alleghany Mountains, and by him forwarded to us:

"*Dear Sir:*—I take the liberty of writing you a confidential letter suggesting we exchange college honors. I

have the honor to be Dean of the Medical Department of a University in New England. If you will confer the degree of M.D., upon a friend of mine who is now a graduate in medicine, I will ask the Board of Trustees of the above-mentioned University to confer upon you, or one of your colleagues, the honorary degree of A.M. or LL.D., just as the person is qualified to receive. Hoping you will give this matter your immediate attention and forward an early reply, I am very truly,

"DR. P. RIPLEY.

"An envelope was enclosed for the reply directed to 'Dr. P. Ripley, 71 Cornhill, Boston, Mass.'"

Having a reliable correspondent in Boston, he was requested to inform us who Dr. P. Ripley was, and of what "Medical Department of a University in New England" he was Dean? In due time he replied saying that he did not find Dr. P. Ripley's name in either the last city directory or the last New England Medical Register; and further that "71 Cornhill" was the waiting-room of the Horse Railway Company, with no one there who knew of any such person as "Dr. P. Ripley." Whether the letter was intended for a *hoax* or a fraudulent attempt to obtain a diploma, it was equally disgraceful to its author.

EDITORIAL NOTES.

DR. CHAS. T. REBER died at his home, near Fancher, Ill., on the night of May 10, 1889, aged 53 years, 3 months and 22 days, He was a member of the American Medical Association. Was a surgeon of the 48th regiment Pennsylvania volunteers during the late war. He was a close student and a conscientious practitioner.

THE PROPOSED MEMORIAL TO THE LATE PROF. MOSES GUNN.—The Alumni and Faculty of Rush Medical College, Chicago, have been for some time engaged in the effort to raise by subscription a fund for the purpose of erecting in the college building a bronze to serve as a memorial of the late Professor Moses Gunn. Those purposing to contribute to the fund are reminded that their subscriptions cannot be received after the 15th of June. Sums varying from one to ten dollars can be sent to the College Clerk, Mr. F. J. Gould.

THE NEXT ANNUAL MEETING OF THE ILLINOIS STATE MEDICAL SOCIETY will be held in Chicago on the third Tuesday in May, 1890. The following are the officers for the ensuing year: President, Dr. John Wright, of Clinton; First Vice-President, Dr. J. P. Matthews, of Carlinville; Second Vice-President, Dr. T. M. Cullimore, of Jacksonville; Permanent Secretary, Dr. D. W. Graham, of Chicago; Assistant Secretary, Dr. L. Ware, of Chicago; Treasurer, Dr. Thomas McIlvaine, of Peoria.

DR. H. ISAAC JONES, who has been an active practitioner in Scranton, Pa., for fifteen years past, has changed his residence to 118 Grant Ave., San Francisco, Cal.

SURGERY AT THE INTERCOLONIAL CONGRESS.—The special correspondent of the *British Medical Journal*, in reporting the proceedings of the Surgical Section of the Intercolonial Medical Congress of Australasia, recently held at Melbourne, says: Mr. T. N. Fitzgerald, the President of the Congress, delivered the opening address and dealt with the perennial subject of club-foot, especially talipes equino-varus. He has added yet another to the many methods of treatment before us. After subcutaneous division of all tendons and resisting fascial bands, Mr. Fitzgerald introduces a chisel through a valved opening in the skin, and cuts through the neck of the astragalus and the greater process of the os calcis; he then wrenches the foot into position, overcoming any further resistance by "guarded powerful blows" of a mallet. All this is done upon a bloodless limb, and the part is firmly bandaged before Esmarch's cord is removed. Mr. Fitzgerald is able to report that "within a month the patient learns to walk upon his practically new feet." If other surgeons can achieve equally good results, this contribution to surgery is indeed a valuable one. It has distinct advantages over tarsectomy and the excision of bones; but, like these operations, it fails to deal with the faulty position of the os calcis beneath the astragalus. The treatment of hydatids naturally came up, and was exhaustively dealt with by Dr. Davies Thomas, of Adelaide. Dr. Thomas regards the tapping of cysts as both dangerous and ineffectual, and his tables show a mortality of 18.88 from the operation. Evidently more investigation upon this point is needed, for Victorian surgeons—as we are informed—find tapping and aspiration to be in most cases quite sufficient. Twenty successful cases of subrapubic lithotomy, by Mr. O'Hara, form no mean contribution to the subject; and Dr. Tremearne introduced an ingenious method of draining the bladder, which is capable of many applications.

THE CASINO.

Where the Sessions of the Association will be held.

American Medical Association

LIST OF OFFICERS AND PROGRAMME OF THE FORTIETH ANNUAL MEETING.

TO BE HELD AT NEWPORT, R. I., JUNE 25, 26, 27 AND 28, 1889.

GENERAL OFFICERS:

President—W. W. DAWSON, M.D., Cincinnati, Ohio.
Vice-Presidents—W. L. SCHENK, M.D., of Kansas; FRANK WOODBURY, M.D., of Pennsylvania; H. O. WALKER, M.D., of Michigan; J. W. BAILEY, M.D., of Georgia.
Treasurer—RICHARD J. DUNGLISON, M.D., lock box 1274, Philadelphia, Pa.
Permanent Secretary—WM. B. ATKINSON, M.D., 1400 Pine Street, Philadelphia, Pa.
Local Secretary—VALENTINE MATT FRANCIS, M.D., New York.
Librarian—C. H. A. KLEINSCHMIDT, M.D., Washington, D. C.
Chairman Committee of Arrangements—H. R. STORER, M.D., Newport.

The General Sessions will be held at the Music Hall, Bellevue Avenue, adjoining the Ocean House, and those of the Sections at the Newport Casino, also immediately contiguous, which for the first time in its history, and as an act of courtesy, is permitted by its Governors to be occupied for other than the purpose for which it was built.

PROGRAMME OF GENERAL SESSIONS.

FIRST DAY, TUESDAY, JUNE 25.

Assemble in Music Hall, Bellevue Avenue, at 11 A.M.

Meeting called to order by Dr. Horatio R. Storer, Chairman Committee of Arrangements.

Prayer. Rev. Thatcher Thayer, D.D. (Cong.), the senior clergyman of Newport.

Reading names of delegates and others thus far registered, by permanent Secretary, Dr. Wm. Atkinson, of Philadelphia.

Announcement of the programme for the day, of halls for the Sections, that papers not already listed be handed to Chairman of Committee of Arrangements for reference to appropriate Sections, that Judicial Council meet at 2 P.M. at Newport Casino, and that, to prevent the usual haste and confusion, the delegates from the different States hold their separate meetings, to elect members of the Nominating Committee, at 9:30 A.M. Wednesday, at the Music Hall, half an hour before the general session.

Address of Welcome by Hon. Thomas Coggeshall, Mayor of Newport; by Dr. Henry E. Turner, of Newport, President of State Board of Health, on behalf of the profession of Newport; and Hon. James H. Eldredge, M.D., of East Greenwich, ex-President of Rhode Island Medical Society, on behalf of the profession of Rhode Island.

Presidential Address, Dr. W. W. Dawson, of Cincinnati, Professor of Surgery in the Medical College of Ohio.

SECOND DAY, WEDNESDAY, JUNE 26.

Meeting called to order by the President of the Association at 10 A.M.

Prayer.

Reading continuation of registry list, of programmes for the day, and call for reports of elections to Nominating Committee.

Address on Medicine, by Dr. Wm. Pepper, of Philadelphia, Provost of the University of Pennsylvania.

Report of the Trustees of THE JOURNAL.

Consideration of proposed Amendments to the Constitution.

Announcement of Nominating Committee, and that it will report at close of Thursday's general session.

THIRD DAY, THURSDAY, JUNE 27.

Meeting called to order by the President at 10 A.M.

Prayer.

Reading of continuation of registry list, and of programmes for the day, and notice that all new business must be introduced at to-day's session.

Address on Surgery, by Dr. Phineas S. Conner, of Cincinnati.

Introduction of New Business.

Report of Treasurer.

Report of Librarian.

Report of Rush Monument Committee.

Report of Nominating Committee.

FOURTH DAY, FRIDAY, JUNE 28.

Meeting called to order by the President at 9 A.M.

Prayer.

Reading of continuation of Registry list, and of programmes for the day.

Address on State Medicine, by Dr. W. H. Welch, of Baltimore.

Report of Necrologist.

Reading names of newly elected officers of the Sections and Delegates to Foreign Societies.

Introduction of the President-elect by the retiring President.

Response by the former.

Final Adjournment.

PROGRAMME OF SECTIONS.

Section on the Practice of Medicine, Materia Medica, and Physiology.

Chairman—F. C. Shattuck, M.D., Boston.
Secretary—G. A. Fackler, M.D., Cincinnati.

FIRST DAY—JUNE 25.

1. Address of the Chairman.

2. "On the Passage of Portal Blood into the General Circulation, and its Probable Relation to Toxæmia," by Charles G. Stockton, Buffalo, N. Y.

Discussion by William Osler, Baltimore; W. S. Tremaine, U. S. A.; John H. Musser, Philadelphia.

3. "Dioscorea Villosa—Wild Yam," by J. V. Shoemaker, Philadelphia.

4. "New Plan for the Treatment of Pneumonia," by G. R. Martine, Glen's Falls, N. Y.

5. "Some Clinical Aspects of Vomiting," by John H. Musser, Philadelphia.

6. "Differential Diagnosis of Varicella and Varioloid," by James T. Whittaker, Cincinnati.

7. "Some of the Rarer and Graver Forms of Cinchonism," by I. E. Atkinson, Baltimore.

SECOND DAY—JUNE 26.

1. "Chronic Endocarditis," by Francis Delafield, New York City.

Discussion by William Pepper, Philadelphia; W. W. Gannett, Boston.

2. "On the Nature and Treatment of Chlorosis," by William Osler, Baltimore.

3. "Hydronephrosis, especially as Caused by Functional Disorders of Micturition," by Robert T. Edes, Washington, D. C.

4. "The Induction of Premature Labor in Bright's Disease," by James Tyson, Philadelphia.

5. "The Treatment of Epilepsy," by Charles F. Folsom, Boston.

6. "Alkaloidal Medication per Rectum, A New Method of Medication," by Elmer Lee, St. Louis.

7. "Reynaud's Disease," George M. Garland, Boston.

THIRD DAY—JUNE 27.

1. "The Etiology and Pathology of Typhoid Fever," by Victor C. Vaughan, Ann Arbor, Mich.

Discussion by Henry P. Walcott, Cambridge; William Osler, Baltimore.

2. "The Physiological Action of the Typhoid Fever Poison." by N. S. Davis, Jr., Chicago.

3. "Toxic Agents in the Blood as a Cause of Diseases of the Nervous System," by M. R. Crain, Rutland, Vt.

4. "Some Thoughts on the Etiology, Pathology, and Therapeutics of Phthisis Pulmonalis," by W. L. Schenck, Kansas City.

5. "Food in the Treatment of Consumption," by Solomon Solis-Cohen, Philadelphia.

6. "Trophopathy in Fatty and Fibroid Degenerations, with Presentation of Cases of Cure."

7. "Heat as a factor in Disease," by John H. Hollister, Chicago.

FOURTH DAY—JUNE 28.

1. "The Prophylaxis of Tuberculosis," by James C. Wilson, Philadelphia.

2. "Signs in Disease," by H. M. Brown, Hillsboro', Ohio.

3. "Ulcerative Endocarditis," by J. G. Truax, New York City.

4. "Myalgia," by Gustavus Eliot, New Haven, Conn.

5. "Veratrum Viride in the Treatment of Disease," by Thomas Legaré, Charleston, S. C.

6. "Stomach Rest and Cleanliness," by Mary E. Baldwin, Newport.

Section of Obstetrics and Diseases of Women.

Chairman—W. H. Wathen, M.D., Louisville.

Secretary—A. B. Carpenter, M.D., Cleveland.

1. "Note on the Use of Boric Acid in Gynesic Practice," by W. W. Potter, M.D., Buffalo.

2. "Bimanual Palpation as a Means of Diagnosis in Diseases of the Female Pelvic Organs," by Paul F. Mundè, New York City.

3. "Series of Five Hundred Confinements in a Maternity," by Joseph Price, Philadelphia, Pa.

4. "Observations on Abdominal Section, based on Two Hundred and Fifty Cases," by James B. Hunter, New York City.

5. "A New Procedure of Colpoperineoplasty by Glissement," by A. Doleris, Paris, France.

6. "Stricture of the Urethra in Women," by Ely Van de Warker, Syracuse, N. Y.

7. "The Inversion of the Uterus; Reduction by a New Method; Exhibition of Instruments," by Henry O. Marcy, Boston, Mass.

8. "Observations on Abominal Surgery, with Report of One Hundred Consecutive Cases Done in the Past Year," by W. Gill Wylie, New York City.

9. "Concealed Pregnancy, Its Relation to Abdominal Surgery," by A. Vander Veer, Albany, N. Y.

10. "The Routine Management of Cases of Acute Intestinal Obstruction," by J. Greig Smith, Bristol, England.

11. "The Medals of Benjamin Rush, Obstretrician," by Horatio R. Storer, Newport, R. I.

12. "The Field and Limitations of Supra-Vaginal Hysterectomy, and Methods of Operating," by L. S. McMurtry, Danville, Ky.

13. "Casuistry in Obstetrics." by Theophilus Parvin, Philadelphia, Pa.

14. "Fœtal Pathology," by W. H. Taylor, Cincinnati, Ohio.

15. "Tetanus following Ovariotomy," by Joseph Tabor Johnson, Washington, D. C.

16. Prof. J. Veit, Berlin, Germany. (Subject not given.)

17. "The Obstetrician as a Counselor," by Thomas Opie, Baltimore, Md.

18. "Injuries to the Bladder during Laparotomy," by A. Reeves Jackson, Chicago, Ill.

19. "Craniotomy and its Indications," by Joseph Hoffman, Philadelphia, Pa.

20. "Glandular Endometritis, Illustrated with Microscopic Projection," by Samuel N. Nelson, Boston, Mass.

21. "Electrical Treatment of Salpingitis, with Observations," A. Apostoli, Paris, France.

22. "Pelvic Abscess in the Female," by Wm. H. Parrish, Philadelphia, Pa.

23. "The Recognition and Treatment of Lacerations of the Cervix by the Obstetrician," by Henry C. Coe, New York City.

24. DeLaskie Miller, Chicago, Ill. (Subject not given.)

25. Prof. Gusserow, Berlin, Germany. (Subject not given.)

26. "Reasons for Drainage in Ovariotomy," by Hampton E. Hill, Saco, Me.

27. "When and What Kind of Obstetrical Forceps Should be Used," by Wm. S. Stewart, Philadelphia, Pa.

28. "Chronic Cystitis in the Female," by Augustus P. Clarke, ——, Mass.

29. "Results of Removal of Uterine Appendages After One or More Years," by S. C. Gordon, Portland, Me.

30. "The Indications for, and Limits of, the Operation for the Removal of the Uterine Appendages," by E. E. Montgomery, Philadelphia, Pa.

31. "Observations in Connection with S. Weir Mitchell's Mode of Producing Fat and Blood," by W. H. Bond, St. Louis, Mo.

32. "Peritoneal Effusions," by Wm. H. Meyers, Ft. Wayne, Ind.

33. "The Rectification of Malpositions of the Head by Rotation with the Forceps," by Edward J. Ill, Newark, N. J.

34. "Pregnancy in the Retroversed Uterus, with Cases," by James R. Chadwick, Boston, Mass.

35. "The Therapeutic Value of Electricity in Gynecology," by L. S. Fox, Lowell, Mass.

36. "Alexander's Operation, with a New Method of Securing the Round Ligaments," by A. B. Carpenter, Cleveland, Ohio.

37. "The Use of Glycoboron in Gynecology," by Wm. Thornton Parker, Providence, R. I.

38. Bache McE. Emmet, New York City. (Subject not given,)

39. "Emmet's Buttonhole Operation," by Virgil O. Hardow, Atlanta, Ga.

40. "On the Treatment of Cancer of the Uterus," by Thomas Moore Madden, Dublin, Ireland.

41. W. E. B. Davis, Birmingham, Ala. (Subject not given.)

42. "A New Two-Ways Catheter for Uterine Irrigation," by A. Cordes, Geneva, Switzerland.

43. "The Application of Forceps to Transverse and Oblique Positions of the Head; Description of a New Forceps," by Henry D. Fry, Washington, D. C.

44. "The Galvanic Current in Gynecology," by A. Lapthorn Smith, Montreal, Canada.

45. "Tubal Pregnancy; Delivery at Six Months per Vias Naturales; Recovery," by Wm. M. Fineley, Altoona, Pa.

46. Thomas E. McArdle, Washington, D. C. (Subject not given.)

47. George R. Shepherd, Hartford, Conn. (Subject not given.)

48. W. B. Carson, St. Louis, Mo. (Subject not given.)

Section on Surgery and Anatomy.

Chairman—N. P. Dandridge, M.D., Cincinnati.

Secretary—W. O. Roberts, M.D., Louisville.

TUESDAY, JUNE 25—FIRST DAY.

1. "On the Surgery of the Lateral Ventricles of the Brain," by W. W. Keen, Philadelphia.

Discussion, J. Collins Warren, Boston.

2. "Concussion of the Spine in its Medico-Legal Aspect," by H. H. Smith, Philadelphia.

Discussion by Herbert Judd, Galesburg; B. A. Watson, Jersey City; Edmund Andrews, Chicago.

3. "Surgery of Peripheral Nerves," by Maurice Richardson, Boston.

4. "Pathology and Treatment of Chronic Sciatica," by J. G. Carpenter, Stanford, Ky.

5. "Suspension and Extension in the Treatment of Chronic Sciatica," by C. C. Hunt, Dixon, Ill.

6. "Arthrectomy of Knee Joint," by E. H. Bradford, Boston.

WEDNESDAY—SECOND DAY.

1. "The Treatment of Stone in the Urinary Bladder," by W. T. Briggs, Nashville.

2. "Litholapaxy," by A. T. Cabot, Boston.

3. "Litholapaxy in Children," by Dudley Allen, Cleveland.

Discussion—"Choice of Operation for Stone," J. W. S. Gowley, New York; C. T. Gardner, Providence.

4. "Management and Treatment of Large Hernia," by J. Collins Warren, Boston.

5. "Open Wound Treatment of Hernia," by H. O. Marcy, Boston.

6. "Properitoneal Hernia," by Thomas W. Dulles, Philadelphia.

7. "Epicystic Surgical Fistula for Relief of Vesical Catarrh," by J. D. S. Davis, Birmingham, Ala.

THURSDAY—THIRD DAY.

1. "Some Further Considerations and Statistics of Abdominal Sections for Traumatism," by Thos. S. K. Morton, Philadelphia.

2. "Pelvic Surgery by Abdominal Section, its Past, Present and Future," by Jos. W. Price, Philadelphia.

3. "Peritonitis," by J. M. Baldy, Philadelphia.

4. "Drainage in Abdominal Surgery," by Charles B. Penrose, Philadelphia.

5. "A Plea for Early Abdominal Work," by M. Price, Philadelphia.

6. Title not received, by L. S. McMurtry.

7. "Chylous Cyst of Mesentery, with Report of a Case," by N. B. Carson, St. Louis.

8. "The Use, 25 Years Ago, of Polarity, Locating the whereabouts of a Leaden Bullet in the Body of a Brave Soldier," by Addinell Hewson, Philadelphia.

9. Fistula in Ano," by J. M. Matthews, Louisville.

10. "Wiring the Patella in Old Ununited Fracture," by W. C. Will, Danbury.

11. "The Healing of Aseptic Bone Cavities by Inplantation of Antiseptic Decalcified Bone," by N. Senn, Milwaukee.

12. "Electrolysis in the Treatment of Stricture of the Rectum," by Robert Newman, New York.

13. "A New Rib Cutter, and a Case of Resection of Ribs for Drainage of a Pulmonary Cavity," by Charles Denison, Denver.

14. "The Absorption of Dead Bone," J. B. Hopkins, Philadelphia.

Section on State Medicine.

Chairman—J. Berrien Lindsley, M.D., Nashville, Tenn.

Secretary—S. T. Armstrong, M.D., U. S. Marine Hospital Service, New York, N. Y.

TUESDAY—JUNE 25, 2 P.M.

Section called to order. Announcement of titles of volunteer papers to be read Friday, June 28.

"The American Medical Association and its Relations to the Public Health," by N. S. Davis, Chicago, Ill.

"International Comity in State Medicine," by John B. Hamilton, Washington, D. C.

"Volunteer Sanitary Organizations as an Aid to Public Boards of Health," by H. R. Storer, Newport, R. I.

"The Importance and Essential Needs of Local Boards of Health," by W. C. Rives, New York, N. Y.

"Modern Sanitary Conditions," by Geo. E. Waring, Jr., Esq., Newport, R. I.

"Rural Sanitation," by Thos. M. Flandrau, Rome, N. Y.

"Report of the Committee on Uniform Medical Legislation in the United States," by Perry H. Millard, Chairman.

"Medical Legislation in the United States," by Perry H. Millard, St. Paul, Minn.

WEDNESDAY—JUNE 26.

Called to order; reading of minutes of preceding meeting.

Annual Address of the Chairman, by J. Berrien Lindsley, Nashville, Tenn.

1. "Quarantine of the Future," by W. C. Van Bibber, Baltimore, Md.

Discussion opened by J. H. VanDeeman, Nashville, Tenn.

2. "Etiological Relations of Water to Disease," by F. L. Sim, Memphis, Tenn.

3. "The Purification of Drinking Water for Cities," by Charles V. Chopin, Providence, R. I.

4. "Bacteriological Examination of Several Native Mineral Waters in the Bottled State," by George Minges, Dubuque, Ia.

5. "Report of the Standing Committee on Meteorological Conditions," by N. S. Davis, Chairman.

6. "The Climatic Causation of Consumption," by Henry B. Baker, Lansing, Mich.

7. "Climatological Characteristics of Salt Lake City," by F. S. Bascom, Utah.

8. Ranch Life in Texas for Consumptives," by J. R. Briggs, Dallas, Tex.

9. "Biometry, or the Measure of Life as Applied to Life Assurance," by Charles Everett Warren, Boston, Mass.

THURSDAY—JUNE 27.

Called to order; reading of minutes of preceding meeting.

Election of officers for the Section for the ensuing year.

1. "The Necessity for Sanitary Supervision of Schools," by George H. Rohé, Baltimore, Md.

Discussion opened by W. L. Schenck, Osage City, Kas.

2. "Do the Sanitary Interests of the United States Demand the Annexation of Cuba?" by Benjamin Lee, Philadelphia, Pa.

3. "Personal Disinfection in Scarlatina," by L. D. Waterman, Indianapolis, Ind.

4. "Report of the Committee on Fœticide," by I. M. Quimby, Chairman.

5. "The Causation and Restriction of Infantile Mortality," by V. C. Vaughan, Ann Arbor, Mich.

6. "Is it Detrimental to the Health of Passengers on Shipboard to Convey to Port the Bodies of Persons who Die at Sea of Non-contagious Disease?" by I. N. Quimby, Jersey City, N. J.

7. Disposal of House Refuse," by Alfred L. Carroll, New York, N. Y.

8. "The Benefits of Sanitation Applied to Obstetrical and Gynecological Surgery," by T. A. Ashby, Baltimore, Md.

9. "Stamina," by A. N. Bell, Brooklyn, N. Y.

FRIDAY—JUNE 28.

Called to order; reading of minutes of preceding meeting.

Reading of volunteer papers.

Section on Ophthalmology.

Chairman—George E. Frothingham, Ann Arbor, Mich.

Secretary—G. C. Savage, Nashville, Tenn.

FIRST DAY—JUNE 25.

1. Address by the Chairman, Geo. E. Frothingham, Ann Arbor, Mich., "The Need of Discussing Ophthalmic Subjects."

2. "The Prevention of Pain and the Improvement of the Stump following Evisceration of the Eye," by A. E. Prince, Jacksonville, Ill.

3. "What can we do to Induce the Government to Make the Census of 1890 Contribute Efficiently to a Clear Conception of the Causes of

Blindness in the United States," by Robert Tilley, Chicago.

4. "Advances in Our Knowledge of some Cerebral Ocular and Intra-Ocular Lesions which Facilitate the Diagnosis and Treatment of Important Diseases," by H. W. Williams, Boston.

5. "Ocular Symptoms of Diseases and Injuries of the Spinal Cord," by J. F. Fulton, St. Paul, Minn.

6. "Impaired Vision as a Result of Sunstroke," by A. R. Baker, Cleveland, O.

7. "Some Cases of Inflammation and Atrophy of the Optic Nerve, with Special Reference to Etiology and Prognosis," by J. L. Thompson, Indianapolis, Ind.

8. "The Non-Surgical Treatment of Strabismus Convergens," by E. J. Gardiner, Chicago.

9. "Tobacco Amaurosis," by Leartus Connor, Detroit.

10. "Paralysis of Accommodation from Concussion of Eyeball; Treatment," by Eugene Smith, Detroit, Mich.

SECOND DAY—JUNE 26.

1. "A Case of Sympathetic Irido-Choroiditis, Induced by Sarcoma of the Choroid, and Appearing Five Days After the Enucleation of the Sarcomatous Eye," Interesting Clinical History and Final Recovery," by F. C. Hotz, Chicago.

2, "Tumors of the Optic Nerve," by S. C. Ayres, Cincinnati.

3. "The Needless and Annoying Restraints after Eye Operations," by J. J. Chisolm, Baltimore.

4. "The Advantage of a Preliminary Iridectomy in Cataract Extraction," by LeRoy Dibble, Kansas City.

5. "Keratitis Trachomatosis," by J. H. Thompson, Kansas City.

6. "Gradation of Lenses," by Dudley S. Reynolds, Louisville.

7. "Glaucoma Fulminans, after Operations," by P. D. Keyser, Philadelphia.

THIRD DAY—JUNE 27.

1. "Traumatism of the Eye," by C. M. Hobby, Iowa City.

2, "Ametropia in Schools," by F. B. Tiffany, Kansas City.

3. The Ametropiæ and Their Relation to Insufficiencies of the Recti Muscles," by J. W. Wright, Columbus, O.

4. "Embolus of the Inferior Branch of the Retinal Artery Visible with the Ophthalmoscope, Disappearance of Embolus and Recovery of the Greater Part of Visual Field under Massage and Nitrite of Amyl," by H. Gifford, Omaha, Neb.

5. "Intra-Ocular Diseases Caused by Chronic Rhinitis," by J. G. Sinclair, Nashville, Tenn.

Other papers have been promised, but as yet the subjects have not been announced. All who expect to read papers are requested to send the title at once, either to the Chairman or Secretary of the Section, otherwise they can not be placed upon the programme of proceedings, which will be published soon by the Committee of Arrangements.

Section on Diseases of Children.

Chairman—J. A. Larrabee, M.D., Louisville.
Secretary—C. J. Jennings, M.D., Detroit.

FIRST DAY, JUNE 25.

1. "The Management of Infants during the First Year," by T. B. Greenley, West Point, Ky.

2. "Cow's Milk for Infant Food," by E. F. Brush, Mt. Vernon, N. Y.

3. "Summer Diarrhœa and Dysentery" by N. Guhmann, St. Louis, Mo.

4. "Intestinal Diseases of Children during Hot Weather," by Peter Hooper, Philadelphia, Pa.

5. "Cholera Infantum, its Etiology and Treatment," by Steele Bailey, Stanford, Ky.

SECOND DAY, JUNE 26.

1. "Heart Failure in Diphtheria," by Geo. Wheeler Jones, Danville, O.

2. "Intubation of the Larynx, with Reports of Cases," by F. E. Waxham, Chicago, Ill.

3. "Scarlatina" by C. R. Earley, Ridgeway, Pa.

4. "Pathology and Treatment of Certain Complications of Scarlet Fever," by Talbot Jones, St. Paul, Minn.

5. "The Value of Hydrogen Dioxide in the Treatment of Diseases of Children," by Marcus P. Hatfield, Chicago, Ill.

6. "A Rule with Penalty in Public Schools," by David I. Booth, Sparta, Ill.

7. "Poliomyelitis Anterior Acuta," by S. P. Deahofe, Potsdam, O.

THIRD DAY, JUNE 27.

1. "Serious Abdominal Injuries of Children," Resulting from Traumatisms Seemingly Trivial," by I. N. Love, St. Louis, Mo.

2. "Visceral Neuralgias in Children," by J. C. Wilson, Philadelphia, Pa.

3. "Atropine in Eneuresis," by Wm. Perry Watson, Jersey City, N. J.

4. "Adherent Præputium Clitoridis as a Cause of Chorea, with Report of a Case," by C. Henri Leonard, Detroit, Mich.

5. "A Further Study of the Cardiac Relations of Chorea," by Wm. Osler, Philadelphia, Pa.

6. "The Treatment of Heart Disease in Children," by J. A. Robison, Chicago, Ill.

FOURTH DAY, JUNE 28.

1. "The Physical Education of Children," by A. H. P. Leuf, Philadelphia, Pa.

2. "The Treatment of Tubercular Bone Lesions before the Joint is Invaded," by V. P. Gibney, New York.

3. "Notes on Surgical Diseases of Children," by Edwin Brock, St. Louis, Mo.
4. "Spine Bifida," by Norman Teal, Kendallville, Ky.
5. "Trismus Nascentiam," by A. V. Williams, Frankfort, Ky.

Papers have been promised from Jerome Walker, Brooklyn, N. Y., W. B. Atkinson, Philadelphia, Pa.

Section of Dental and Oral Surgery.

Chairman—F. H. Rehwinkle, Chillicothe, O.
Secretary—E. S. Talbot, Chicago.

TUESDAY, JUNE 25.

Address by T. H. Rehwinkle, Chairman.
1. "Facial Neuralgia Associated with Pregnancy," by W. W. Allport.

WEDNESDAY, JUNE, 26.

1. "Diseases of the Antrum," by Wm. Carr.
2. "Fissures," by R. R. Andrews.

THURSDAY, JUNE, 27.

1. "Care of the Teeth of Pregnant Women," by John Marshall.
2. "Statistics of Irregularities of the Teeth of Normal Individuals, the Idiotic, Deaf and Dumb, Blind and Insane," by Eugene S. Talbot.

Numerous other papers have been promised.

Section of Medical Jurisprudence.

Chairman—J. G. Kiernan, M.D., Chicago.
Secretary—S. C. Evans, M.D., Baltimore.

FIRST DAY, JUNE 25.

1. "History of Medical Jurisprudence," by Judge Amos G. Hull, New York.

SECOND DAY, JUNE 26.

1. "Tests of Insanity," by H. N. Moyer, Chicago.
2. "Monomania," by Clark Bell, New York.
3. "Legal Decisions on Insanity"—Chairman's Address, by Jas. G. Kiernan, Chicago.
4. "Massachusetts Insanity Laws," by T. W. Fisher, Boston.
5. "Illinois Insanity Laws," by Harriet C. B. Alexander, Chicago.

THIRD DAY, JUNE 27.

1. "Legal Aspects of Inebriety," by T. L. Wright, Bellefontaine, Ohio.
2. "Inebriate Criminals," by T. D. Crothers, Hartford, Conn.
3. "Social Aspects of Alcoholism," by E. C. Spitzka, New York.

FOURTH DAY, JUNE 28.

1. "Spinal Concussion," by S. V. Clevenger, Chicago.

Section on Dermatology and Syphilography.

Chairman—L. Duncan Bulkley, New York.
Secretary—W. T. Corlett, Cincinnati, O.

FIRST DAY, JUNE 25.

1. Address by the Chairman, "Recent Advances in the Treatment of Diseases of the Skin."
2. Discussion on "The Treatment of Tinea Tonsurans," opened by W. T. Corlett, and Henry Fleischner."
3. "The Prophylaxis of Ringworm of the Scalp," by Fred. J. Leviseur, New York.
4. "Some notes on Hoang-nan," by J. V. Shoemaker, Philadelphia.
5. Analysis of 250 Cases of eczem-seborrhoicum," by George T. Elliot, New York.
6. "Prurigo hiemalis, or Winter Itch," by W. T. Corlett, Cleveland, Ohio.
7. "Dermatitis Exfoliativa," by E. N. Brush, Philadelphia.

SECOND DAY, JUNE 26.

1. "Discussion on "The Indications for and Duration of the Treatment of Syphilis, opened by L. Duncan Bulkley, or another.
2. "The Positive Diagnosis of Syphilis," by Ephraim Cutter, of New York.
3. "On Pruritus," by Henry Fleischner, New Haven, Conn.
4. "A Case of Painful Subcutaneous Neuroma (Neuro-fibroma)," by J. Abbott Cantrell, Philadelphia.
5. "Relations between Acne and Diseases of the Nasal Cavity," by Carl Seiler, Philadelphia.
6. "Answers to questions Deposited in Question Box Relating to Dermatology or Syphilography.

THIRD DAY, JUNE 27.

1. "A Case of Kraurosis Vulvæ," by A. H. Ohman-Dumesnil, of St. Louis, Mo.
2. "Use and Abuse of Soap and Water," by Merrill Ricketts, Cincinnati, O.
3. "The Treatment of Felon without Incision," by J. S. Miller, York, Penn.
4. "The Early Recognition and Treatment of Epithelioma," by L. Duncan, Bulkley, New York.

Section on Laryngology and Otology.

Chairman—W. H. Daly, M.D., Pittsburg.
Secretary—E. F. Ingals, M.D., Chicago.

1. "The Third Tonsil; Its Important Relation to Naso-Pharyngeal and Naso-Aural Catarrh," by Joseph A. White.
2. "Adenoid Hypertrophy of Vault of Pharynx —Pathology and Treatment," by Bryson Delevan.
3. "The Benefits to be Derived from the Radical Operation for the Relief of Nasal Stenosis," by Holbrook Curtis.

4. "Obstruction of the Nares Causing Nervousness," by Hal Foster.

5. "Empyema of the Frontal Sinus," by Geo. A. Richards.

6. "Clinical Notes," by J. D. Arnold.

7. Short Address, by Lennox Brown.

8. "An Analysis of One Hundred Cases of Cough Cured by Adoption of Operative Procedure in the Treatment of Existing Morbid State of Nasal Cavities," by J. E. Schadle.

9. "Clinical Observations in a Number of Cases," by Carl Seiler.

10. "A New Gag, and Some Conservative Observations about Intubation," by Chas. Denison.

11. "Internal Ear Deafness, Illustated with Cases," by J. G. Carpenter.

12. "On the Value of Antiseptic Treatment of and Protection of Membrana Tympani in Perforation," by Laurence Turnbull.

13. "Report of Cases of Dangerous Middle-Ear and Mastoid Inflammations, which followed Treatment of Naso-Pharynx," by J. L. Thompson.

14. "Observations upon the Effect of Nasal Obstruction on the Middle-Ear," by F. Whitehall Hinkel.

15. "The Indications for the Excision of the Drumhead of the Ear," by Samuel Sexton.

16. "The Possible Danger to Middle-Ear as a Result of Nasal Atomization," by C. W. Richardson.

17. "Nasal Polypi in Children, and Double Uvula," by John McKenzie.

18. "The Relation of Tonsilitis to Rheumatism," by S. J. Radcliff.

19. "Morbid Perforations of Nasal Septum," by A. B. Thrasher.

20. "Perforating Ulcer of the Septum Narium," by Max Thorner.

21. "Chronic Obstipation of the Nares; Hernia," by W. Frendenthal.

22. "Affections of the Throat as Evidence of Diseases in other Localities," by Jas. E. Logan.

23. "Epilepsy Caused by Intra-Nasal Disease," by F. S. Crossfield.

24. "Effects of Natural Gas upon Upper Air Passages," by D. W. Rankin.

25. "The Influence of Disorders of Digestion on Catarrh of Air Passages," by A. M. Duncan.

26. "The Treatment of Acute Naso-Pharyngeal Catarrh," by S. S. Bishop.

27. "Congenital Occlusion of Naso-Pharynx, with Report of Two Cases," by F. O. Stockton.

28. "On the Use of Menthol in Upper Air-Passages," by Frank H. Potter.

29. "Menthol in Laryngeal Phthisis," by C. H. Knight.

30. "Sclerosis of Mastoid Cells," by J. B. Lippincott.

31. "Malignant Tumors of Larynx," by H. A. Johnson.

32. "Laryngeal Gummata," by Robert Levy.

33. Glandular Hypertrophies at the Base of Tongue," by John O. Roe.

34. "A Case of Acute Rheumatic Laryngitis of Gonorrhœal Origin," by Wm. K. Simpson.

35. "Abscess of the Antrum of Highmore; Its Diagnosis and Treatment," by J. H. Bryan.

36. Nasal Bacteria," by Jonathan Wright.

37. "Treatment of Cystic Goitre," by E. Fletcher Ingals.

Papers are also expected from the following, but the titles have not been received:

Drs. E. L. Shurly, Louis Jurist, Wm. Porter, J. Mount Bleyer, Chas. E. Sajous, Thos. Legaré, Chas. Stover Allen, J. Solis-Cohen, C. E. Bean, F. I. Knight, W. E. Casselberry, E. R. Lewis.

Others desirous of reading papers in any of the Sections should at once send the title of their paper to Dr. H. R. Storer, Newport R. I., and to the Chairman of the Section in which they wish to read it.

HOTELS.

In Newport.—Ocean House, Bellevue Ave., $4 per day, (special rate); The Aquidneck, Pelham St., $3 per day, (special rate); Brayton House, Pelham St.; Cliff Ave. Hotel, on the Cliffs, $2.50–$3; Perry House, Washington Square; Central House, 14 Bath Road.

In Jamestown—(Eighteen minutes by steam ferry from Newport. Boat making trips about every hour, each way.) Bay View House, C. T. Knowles, $2 per day; Gardner House, Gardner & Littlefield, about $2 per day; Prospect House, C. E. Weeden, $2 per day; Champlins', Wm. A. Champlin, $1.50 per day.

PRIVATE BOARDING HOUSES. $1.25 TO $5 PER DAY.

Ailman, Miss R. L., 62 Spring Street; Allen, Samuel, 79 Washington; Bailey, Mrs. John C., 84 John; Barker, Mrs. James P., 15 Clinton Ave.; Barker, Mrs. Jos. P., 304 Broadway; Bateman's, Brenton's Point; Bateman, Mrs. Joseph, Kay St. House; Bliss, Mrs. W. H., 6 West Marlboro; Bosworth, Mrs. P. S., 35 Spring; Bryer, Mrs. Peleg, 12 Park; Burbridge, Mrs. J., cor. Corné and Mill; Clark, Mrs. A. M., 42 John; Dame, Miss E. M., 78 Broadway; Dawley, Mrs. S. E., 24 John; Eldredge, Mrs. A. E., 36 Washington; Ellis, Mrs. J. J., 72 John St.; Essex, J. J., 252 Thames; Finch, Mrs. J. B., 27 High; Gifford, Miss M. A., 25 Farewell; Hall, Mrs. E. A., 137 Broadway; Henderson, Mrs. H. R., 1 Wanton Ave.; Kreis, Mrs. H. K., 101 Prospect Hill St.; Nason, Mrs. Geo., 28 John; Peckham, E. Truman, 7 Arnold Ave.; Peters, Mrs. Anton, 34 Broadway; Richardson, J. D., Jr., 13 Summer; Robinson, Mrs. M. J., 14 Catherine; Rudolph, Mrs., 106 Church; Russell, James M., 49 Washington; Seabury, Mrs. T. M., 16 Mann; Sisson,

Mrs. A. P. 81 Touro: Snow, Mrs. A. C., 8 Pelham; Swasey, Mrs. J. H., 74 Spring; Thurston, Mrs. Harriet, 92 Division; Townsend, H. A., 15 Rhode Island Ave.; Weaver, Mrs. Jacob, 216 Thomas St.; White, Mrs. Annie, 63 Broadway; Wilbour, Misses M. A. and H. L., 50 Washington; Wilbur, Mrs. A. A., 131 Church; Williamson, Mrs. E. F., 33 Ann.

PRIVATE LODGINGS (WITHOUT MEALS). FIFTY CENTS TO $1 PER DAY.

Bishop, Mrs. A. H., 16 Chestnut St.; Brown, John, 18 Newport Ave.; Bullock, Mrs. Joseph H., 87 John; Congdon, Mrs. C. T., 100 Spring; Finlay, Mrs. A. M., 80 John; Goddard, Mrs. L., 38 John; Greene, A. M., 54 John; Hammond, Mrs. C. E., 12 Appleby Ave.; Kelley, Mrs. G. H., 16 Bay View Ave.; Lawton, H. R., 66 John; Leddy, Mrs. M. S., 38 Franklin; Lee, Mrs. Wm. H., Corné St.; Martin, Miss, L. D., corner John and Martin Sts.; Milne, Mrs. W. O., 8 Everett; Mumford, Miss H. E., 8 N. Baptist St.; Ordway, Mrs., 84 Division; Pitman, Mrs., corner Martin and Prospect Hill Sts.; Simmons, Mrs. W. B., 9 Meeting St.; Slocum, Mrs. Geo. S., 35 Green; Stanton, Mrs. R. H., 42 Washington Square; Stewart, Mrs. J. C., 80 Division; Titus, Mrs. I. W., 14 Everett; Weeden, Mrs. C. D., 2 Allen Ct.

Notice to Exhibitors.

For the accommodation of exhibitors the local committee of arrangements has contracted for the erection of a temporary building as the most feasible and advantageous provision which can be made for the display. This building is to be put up on a lot the use of which is gratuitously given for the purpose by John G. Weaver, Esq. The lot adjoins the lot on which stands the Music Hall, in which the general sessions of the Association are to be held, and it is also contiguous to the Ocean House, the largest hotel. The contract provides for a one story, sloping roof structure, twelve feet high at the eaves, built of planed, matched, grooved and tongued boards, the studding and floor planed, with windows eight feet apart from centre to centre, the whole wind and rain proof. This building is to be made of a size to accommodate such accepted exhibitors as have made application for space previous to May 30. By the return of the material to the builder after use the net cost of the building is to be at the rate of $19.00 for each 100 square feet of floor space. Out of this floor space must be taken room for aisles, and there will be some few incidental small expenses, as for night watchman, safeguards against fire, etc., so that the cost to exhibitors will be at a rate somewhat exceeding $20.00 for each 100 square feet of floor space occupied. The committee will try to keep the sum total of expense as low as possible for satisfactory accommodations, and to divide the whole cost equitably among the exhibitors. The building is to be so situated in a large lot as to have air and light on all four sides; there is to be an entrance at each end, and there can be no poor location in it. In the assigning of space regard will be had as far as possible to priority of applications, to expressed preferences and varied needs of exhibitors, and to economy of space. The committee consider themselves as acting as agents of the exhibitors for the mutual convenience of the whole, and they can assume no responsibility for the safety of exhibits. If insurance of any kind on exhibits be desired, it should be procured by the owners.

C. A. BRADSETT,
E. P. ROBINSON,
Sub-Com. on Exhibits, Am. Med. Association.

Railroad Arrangements.

The Local Committee of Arrangements and the Committee of Transportation at Newport hope to be able to announce definitely in the next issue of THE JOURNAL, that arrangements have been perfected whereby members and those who accompany them to the forthcoming meeting will be able to purchase their tickets at a rate not to exceed one fare and a third for the round trip. It is expected that the various railroads will grant this courtesy, and whether the tickets will be sold on the certificate plan for the entire distance, or whether round trip tickets will be sold at the starting-point to the place of meeting, are subjects that are being actively discussed by the various Traffic Associations at the time we go to press for this issue of THE JOURNAL.

Dr. Liston H. Montgomery, 189 Randolph St., Chicago, has been appointed a member of the Transportation Committee.

SOCIETY PROCEEDINGS.

The American Surgical Association.

Annual Meeting, held in the New Army Medical Museum, Washington, May 14, 15, and 16, 1889.

(*Continued from page 751.*)

DR. CLAUDIUS H. MASTIN, of Mobile, read a paper on

HERNIA—A COMPARISON OF THE VARIOUS METHODS ADOPTED FOR ITS RADICAL CURE,

inviting discussion of their respective merits.

Reference was first made to the great frequency of this condition. The Census Reports of 1880 show that of the total number of deaths, 1 in

every 600 was due to hernia, and out of 1,236 deaths from hernia, 141 occurred in children under one year of age. A historical review of the various operations proposed for the radical cure of hernia from the earliest times down to the present, was then given.

The paper proper concluded with the following remarks:

"The ligature of the sac at its neck, with suture of the pillars of canal and ring, may be considered an established surgical procedure; still being a comparatively new operation, a discussion of its merits will be of practical value in leading to further improvements, and with them permanent success of the operation. With the present lights before us, the most important point in the operation appears to be closing the neck of the sac as high up as possible, so as to effectually seal up the opening into the abdominal cavity. To do this completely it is necessary that the sac should be carefully separated from the adjacent tissues, and this is not always an easy matter, since oftentimes the true sac is obliterated and a new sac formed in the fibrous tissue, with the vascular and nervous distribution blended in such a manner as to render the dissection most difficult, if not impossible. In such a case MacEwen's operation could not be performed, and it would be impossible to twist the sac as recommended by Mr. Ball. This objection does not obtain in crural and umbilical herniæ, still since inguinal is the most frequent of the herniæ, it is of importance in them. In congenital cases, it is much easier to separate the sac and hence more possible to do a complete operation; but since in young children, the truss properly applied and long continued, until the abdominal parieties have been so developed as to increase the obliquity of the canal, will in most instances produce a permanent cure, all operative procedures in children should be considered unwarrantable. In those cases, however, where an imprisoned testicle complicates the condition, the operation is unquestionably proper and the removal of the testicle justifiable, and for the simple reason that the presence of the gland in the canal predisposes to the descent of the hernia.

Since the main point in the success of the operation appears to have been the proper disposal of the sac it is not astonishing that operators who have given it their attention should have adopted diverse methods, each one of which has the same end in view. Whilst Ball twists it, MacEwen tucks it up; Hardee insists upon the importance of inclosing the transversalis fascia with the sac in the ligature; J. D. Bryant splits the pillars on either side and weaves in the sac; Annandale opens the canal, ties the sac, cuts it away and stitches the opening; on the other hand Stokes opens the sac and then stitching the neck, the canal and the pillars together, he leaves the sac in position; Banks opens the sac, ligates the neck, cuts away the fundus and sutures the pillars; Alexander, of Liverpool, opens the canal, ligatures the sac flush with the peritoneum internally, then divides the neck below the ligature, leaving the sac in the canal without suturing the ring; MacCormac advocates this plan, while Buckhanan cuts down to the sac, slits it up longitudinally on each side of the cord, divides the front part horizontally, rolls up the upper part, with which he plugs the internal ring and turns down the lower half to form the tumica vaginalis.

From a comparison of all the methods, it is apparent that no fixed rule of procedure is established, and although the radical operation is a marked improvement in the treatment of hernia, whether free or strangulated, we cannot consider it perfected, because the methods hitherto resorted to have not proved radical in results. The operation is ideally correct, but the question arises, whether, with the uncertainty of success, the risk justifies the operation, especially so if the circumstances of the individual are such that he can content himself with the use of a properly adjusted truss.

DR. M. H. RICHARDSON, of Boston: My experience with the operation for the radical cure of hernia has been small. Sufficient time has not elapsed to permit us to say what the ultimate result will be. My preference has been for the invagination of the sac as proposod by MacEwen. I do not advocate the operation in trivial cases of hernia. Here I believe that the application of a well-fitting truss is the most conservative and better plan.

DR. D. HAYES AGNEW, of Phila.: We have to yet speak with a good deal of reserve as to which is the most successful operation. Sufficient time has not elapsed to enable us to speak positively upon this subject. The operation which seems to me most applicable is that in which the sac is ligated, pushed into the internal ring, stitched there, and transverse sutures passed across the canal. I think that the omentum will constitute an important element in the radical cure of hernia. I believe that in all cases of strangulated hernia we are justified in attempting the radical cure. The same is true in those cases of hernia which cannot be controlled by a truss leaving the patient exposed to great risk.

DR. W. W. DAWSON, of Cincinnati: In cases where life is not in jeopardy we should approach the operation with a great deal of consideration. I have seen very different results from the same operation performed with equal care in cases apparently similar. Where life is in danger, duty impels us to operate, but where the question is one of æsthetics or abridged usefulness, the operation should be approached cautiously.

DR. L. MCLANE TIFFANY, of Baltimore: My operation for radical cure in cases of strangulated hernia are more successful than formerly, and I

attribute this to the fact that I operate now in a more cleanly manner. I think that no operation for strangulated hernia is complete unless an attempt at radical cure is made. When the hernia is not strangulated, the question arises as to the kind of hernia, the inconvenience that it causes, and the circumstances of the individual. I do not believe that the operation, *per se*, is likely to be followed by much trouble. The method to be employed must be determined by the peculiarities of the case. In regard to children, I think in congenital hernia, especially where it is probable that the child will have to work for its living, that it is the duty of the surgeon to operate. Here it is not necessary to open the peritoneum. A ligature is thrown around the sac above and another lower down, and the intervening portion excised, forming a tunica vaginalis below and a peritoneal sac above.

Dr. D. A. Yandell, of Louisville: I believe that in strangulated hernia the surgeon should attempt the radical cure. This has been my practice and I have used various methods. It is difficult for any one man to decide which is the best operation, but in the course of ten years we shall be able to arrive at some opinion. At present it is simply historical and no one can say which is the best method.

Dr. J. Ford Thompson, of Washington: So far as my experience has gone, I think there is very little difference in the operations. The main point is to get rid of the sac. I think that suture of the pillars is useless. The operation that I have employed is practically that of McBurney. In strangulated hernia it seems to me that there must be danger in inverting the sac as in MacEwen's operation. I have seen many cases of hernia in children, but I have never been able to adopt the view of Dr. Tiffany. As a rule, if we can keep the intestine reduced, the hernia is cured in a comparatively short time. In some cases of large hernia in children the radical operation is probably justifiable.

Dr. W. W. Keen, of Philadelphia: We doubtless all agree that in strangulated hernia no operation is complete without an attempt at radical cure. We also agree that in those cases where the hernia is not controlled by a truss and the patient is unable to labor, radical operation is advisable. The tendency at the present time is to extend the limits of the operation beyond these two classes. The presence of hernia is always attended with risk; hence the tendency at present is to operate on a larger number of cases. In children if the retentive measures after a thorough trial for a few years fail to effect a cure, I should be inclined to operate. In very large hernia, I should not be inclined to use MacEwen's method. The life of the sac is imperilled by separating it. In large hernia a certain amount of preparatory treatment is desirable to accustom the abdominal cavity to the presence of the intestine, and thus prevent undue pressure upon the diaphragm and strain upon the sutures. In the more ordinary cases I think that the operation of McBurney is the best. I should place the operations in the following order: McBurney's, Macewen's, and Ball's.

Dr. C. H. Mastin, of Mobile: I have little to add. The object of my paper was to elicit discussion as to the best method of operating. I have performed 34 operations for hernia, with 3 deaths. Two of these may be excluded, as the patients were *in extremis* at the time of the operation. This leaves 32 cases, with 1 death. Of this number there have been 8 radical cures. One of these cases I have watched for seventeen years. The method employed was after the sac was opened to pass a deep pin through the pillars, with an ordinary twisted suture over it, close the incision and place the leg on a double-inclined plane. Thirty-one cases have recovered with primary union. I believe that the cure is produced by the dense cicatricial tissue formed in the canal.

Dr. J. R. Weist, of Richmond, Ind.: I have operated on strangulated hernia 41 times. In 30 cases I have attempted to make a radical cure, using a variety of methods. In only 4 cases have I succeeded in keeping the hernia in. A number have remained well for six months to two years, and then the hernia has reappeared as bad as ever.

Dr. M. H. Richardson, of Boston, read a paper on

THE SURGICAL TREATMENT OF GANGRENOUS HERNIA.

The principal question discussed was the relative advantage of immediate excision and suture of the bowel, and the formation of an artificial anus, with subsequent closure. The views of various authorities were first quoted. The author then briefly reported the cases coming under his own observation.

Case 1.—A young woman with right femoral hernia, strangulated for one week. Bowel was found gangrenous and excised. Death from shock the next day.

Case 2.—Woman, æt. 65 years. Left inguinal hernia. On opening the sac the bowel was found strangulated and dark in color. The hernia was reduced, but the symptoms of obstruction continued, and five days later the sac was opened and the intestine found strangulated by a band within the ring. The bowel was drawn out, the strangulated portion excised and the ends sutured. The patient died of shock.

Case 3.—Woman, æt. 42 years. Had been treated by Christian Scientists for five days. There was a large umbilical hernia, with gangrenous intestine. The sac was filled with fæcal matter. The constriction was found and the bowel drawn out and excised beyond the constric-

tion and the ends united. This patient recovered perfectly and has remained well.

Case 4.—A woman with enormous umbilical hernia, with strangulation and gangrene. The fæcal abscess opened by natural processes and the woman has been in perfect health since, with the exception of the artificial anus. This will be operated on next week.

In the two cases of excision the time required for the passage of the sutures was twenty minutes; the whole operation did not exceed one hour. The longer the operation the more are the chances reduced.

Reference was then made to the use of the bone plates of Senn and the catgut rings of Abbe. These devices may do more in these cases than anything else. Every case must be decided on its merits. The danger to life of resection in suitable cases is probably not greater than the danger of artificial anus with the dangers attending the subsequent closure of the same. The danger of the latter operation is especially great where the opening is near the stomach. Artificial anus is also objectionable on account of the excoriation of skin which attends it, and also the risk of giving way of the sutures.

The author concluded as follows: It seems to be the general opinion of surgeons everywhere that, under some circumstances, excision and suture are justifiable. It seems to me that the primary operation should only be done where all the conditions are favorable. It is preëminently a hospital operation. Every appliance and preparation should be ready for its most perfect performance. It is not an operation to be recommended to the general practitioner or to the unqualified operator. It depends for success more often upon rapid and skilful execution than almost any other operation.

There is no doubt that in some cases this procedure is imperative, where the part necrosed is too high up for intestinal nutrition to be maintained. The difficulty, of course, is to recognize this state of things. Even when it can be demonstrated that the jejunum is gangrenous, excision is not justifiable unless the patient's condition offers some hope, and there is a chance that the relief of the symptoms of obstruction may be followed by sufficient improvement to make a second operation unnecessary.

DR. D. HAYES AGNEW: My experience is too limited to enable me to say much upon this subject. I recall three cases of gangrenous hernia. One was a case of inguinal hernia in which I excised a portion of the bowel. The patient recovered from the immediate effects of the operation and passed out of my hands. Some months afterwards, he was advised by another surgeon to apply a compress to the external opening so as to compel nature to establish a communication between the two portions of bowel. He did so with fatal results. The second case was one of femoral hernia which had lasted six or seven days. It was laid open and the patient recovered. As the granulations filled the opening, communication took place between the two portions of bowel. The third case was one of umbilical hernia. I opened the sac, excised 10 inches of intestine and carefully stitched the ends. The patient died of hæmorrhage at the end of two days. It occurs to me that it would be wise, in such a case, to stitch the intestine to the skin and at a subsequent period do this operation of Dr. Abbe.

DR. WILLIAM T. BRIGGS, of Nashville: Although I have seen many cases of strangulated hernia, I have seen but three instances of gangrenous intestine. In the first case I opened the abscess and the fæcal contents escaped. The patient lived some time, but died of inanition. In the second case I attached the bowel to surrounding parts and made an opening into it. The patient died in twenty-four hours. The third case I left entirely to nature and the patient recovered with an artificial anus.

DR. P. S. CONNER, of Cincinnati: I have had three cases of gangrenous hernia and have seen a fourth in the practice of Dr. Dandridge. The operation of intestinal anastomosis is valuable. It can be performed rapidly, it is simple and establishes the continuity of the intestinal tract more perfectly than any other operation that has been suggested.

DR. W. F. PECK, of Davenport: From my experience, I think that great benefit in the way of prevention would result from educating the subjects of this trouble in regard to the dangers of hernia and the way of reduction.

DR. J. EWING MEARS, of Philadelphia: I have had two cases; one of umbilical hernia in which I made an artificial anus, the other of femoral hernia where I performed resection and returned the intestine to the abdomen. Both resulted fatally inside of forty-eight hours. A surgeon of Vienna has suggested that in these cases the gangrenous intestine be withdrawn from the abdomen and held in place outside by a tampon of iodoform gauze. In this way the intestine can be kept under observation and treated as seems best.

DR. W. W. KEEN, of Philadelphia: I think that the introduction of the method of intestinal anastomosis by the bone plates of Senn or the catgut ring of Abbe is a great advantage over former methods. The mortality following this method is greatly less than that following reunion of the ends of the bowel.

DR. T. A. MCGRAW, of Detroit: I have heard nothing in regard to the pathological condition of the bowel above the seat of stricture. In some cases the bowel is healthy immediately above the point of strangulation, while in others the inflammatory process extends 6 to 10 inches above the point of constriction. This must make a great

difference as regards the results of operation.

DR. A. VANDERVEER, of Albany: Eleven years ago I saw a case of gangrenous inguinal hernia, but the condition was so bad that nothing was done. The patient died a few hours later. Two years ago I saw a similar case, except that the patient was younger and the collapse not so great. I opened freely and left it to nature. The man recovered with an artificial anus.

DR. H. H. MUDD, of St. Louis: I think that gangrenous hernia is not so rare as seems to be the general impression. I can recall at least seven cases. Three of these cases occurred more than four years ago and all died. During the last four years I have operated on four cases, excising a portion of bowel, with recovery in one case.

(To be concluded.)

Philadelphia County Medical Society.

Stated Meeting, March 27, 1889.

THE PRESIDENT, S. SOLIS-COHEN, M.D., IN THE CHAIR.

DR. W. W. KEEN read a paper on

UNCOMPLETED NEPHRECTOMY.

(See page 762.)

DR. DEFOREST WILLARD: I was unfortunately detained, and did not hear Dr. Steinbach's paper, but I understand that in his case the abdominal incision was employed. In Dr. Keen's case the lumbar incision was employed at the operation, but that at the post-mortem an attempt was made to remove the kidney by an abdominal incision in the semi-lunaris. I do not consider that this question in regard to the incision to be employed, is yet settled. As a rule, however, the anterior median method offers better opportunities for diagnosis, for examination of the other kidney, and for safe removal. In cases where a stone is suspected, or the presence of pus is probable, the lumbar incision is certainly proper, the operation may be simply a nephrotomy, and not a nephrectomy, and then we have better drainage. In simple purulent kidney, it is better to secure drainage and not remove the kidney. The results, so far as life are concerned, are better by this method. In tuberculous kidneys, the results of nephrectomy have been more satisfactory. In Bardenhauer's statistics,[1] numbering some thirty-five nephrectomies, where twenty-five were for purulent kidney of various forms, the mortality was not much higher than ordinary nephrectomy. Out of thirty-five cases he lost ten.

The choice of the incision will depend largely upon the condition of the case, and upon the diagnosis. Many nephrectomies have been performed after the abdominal incision has been made for other purposes, as when the ureter has been cut in laparotomy. I do not know why it is any better, but Schmidt recommends that in such cases the kidney be removed by the lumbar incision. It seems to me that this would decidedly delay the operation, and would be more likely to cause contamination of the abdominal cavity. I do not think that the results are much more serious in the anterior operation than they are in the posterior.

My practical experience has been limited to two cases, one for gunshot wound, and the other for a tuberculous kidney, but in both I employed the anterior median route. In the first case there were evidences of wounds of other organs. In the latter case the kidney was pushed far anteriorly, and I thought the abdominal incision the better one.

The difficulties of the lumbar operation are certainly much increased where there is only a short space between the twelfth rib and the crest of the ilium. In Dr. Keen's case he found it impossible to reach the hilum; if he had employed the median incision at the post-mortem operation, instead of the incision through the linea semilunaris, he would have been able to have reached it without difficulty.

In regard to the sutures to be employed in *nephrorrhaphy*, I think that the failures have resulted from the use of catgut. We must employ a permanent suture, which will hold for a long time, and anchor the kidney until it is thoroughly fixed in its position. The question of decubitus is of importance. A month is the shortest possible time we can expect any fixation. The use of pads is very unsatisfactory. We are obliged to apply the pad upon the abdominal walls to an organ that lies deep in the loins with the intestines in front of it. We cannot hope to hold it in position by any such means. Therefore the dorsal decubitus should be maintained for a long time.

DR. M. PRICE: The case of Dr. Steinbach is certainly a very interesting one, and I see no other course save that which he tried, of operating by the abdominal method. Even in Dr. Keen's case, where he states that the first idea was an exploratory operation, I think that the anterior method would have been better. I think it is the better plan, even if after making the diagnosis you close the abdominal incision and remove the kidney by the lumbar method. An incision one and a half inches in length affords ample room for the examination of all the organs. I have twice examined both kidneys through such an opening. In one case of supposed gallstones, I found the viscera attached to the abdominal wall. After separating them, I examined the kidneys without difficulty, and found them in

[1] Berlin. klin. Woch., October 15, 1888. Philadelphia Medical News, December 1, 1888.

good condition. In the case where I removed the kidney, I had no difficulty in feeling both kidneys through a small abdominal incision. I think that if Dr. Keen had made the median abdominal incision, and found the kidney so seriously diseased, he probably would not have made as great an effort as he did through the lumbar incision.

Dr. Steinbach, in his report, does not state whether or not he used drainage. My impression is that the anterior route is the best for drainage, which, in these cases, is of paramount importance. So much tearing is done in releasing the kidney that drainage for twenty-four or forty-eight hours is necessary, or at least can do no harm. I do not believe that any drain answers its purpose so well as one that can be cleaned by the attendant or nurse. The best method to stop oozing of blood is to keep it cleaned away. Keep no blood in contact with the bleeding vessel.

I consider the danger no greater by the anterior than by the posterior method. It is the only method to employ in cases of gunshot wounds.

In regard to the use of morphia, I differ from Dr. Steinbach, unless he had made up his mind that the patient was going to die. I believe that morphia has a tendency to cause suppression of urine. It also lowers the vitality and assists in killing the patient. I should not think of using morphia in abdominal cases unless the patient were dying. Where morphia has been used in surgery, and especially in abdominal surgery, I have had cause to regret it.

DR. JOHN B. DEAVER: I may say a word in regard to the choice of incision. I have operated both by the abdominal and lumbar method. I consider that the anterior incision is preferable in cases of solid growths, particularly where they have reached any size. We run greater risks in attempting to break up the adhesions to the capsule by the lumbar incision, where we cannot see what we are doing, than we do through the anterior incision.

The proper course is, I think, to go through the linea semilunaris. This brings us nearer to the organ, and gives a better opportunity to work to the outer side of the colon, which is important, as the blood-vessels are in relation to the internal layer of the meso-colon, and not with the external layer.

In cases of liquid accumulations in the kidney, I do not think that we operate with quite as much facility anteriorly as posteriorly. The lumbar incision affords better opportunities for drainage under these circumstances, but drainage can be satisfactorily accomplished by the anterior method by the glass drainage tube.

The abdominal incision affords us better opportunities for the examination of neighboring organs. For purposes of diagnosis it is more satisfactory than the operation through the loins.

There is no doubt that nephrorrhaphy the proper form of suture is antiseptic silk. I know of one failure resulting from the use of catgut. It is probably impossible to pass sutures through the capsule of the kidney without also involving the substance of the organ, yet I think if we could avoid wounding the kidney it would be better. I have no doubt that the appearance of albumin in Dr. Keen's case after the operation, was due to the sutures.

In regard to the meso-nephron, I have seen several cases of floating kidney in the dissecting-room, and I have yet to meet with an instance of a reflection of the peritoneum which could be called a meso-nephron. While I would not differ from so distinguished an authority as Dr. Morris, yet I have not met with this condition.

The question of removal of solid growths of the kidney is largely influenced by the age of the patient. It is almost useless to operate for carcinoma of the kidney in early life or in late life, so that the middle period offers the best chances for a favorable result in these cases.

DR. THOMAS R. NEILSON: In looking over the literature of nephrectomy, one is struck by the variableness of operators as to the method chosen to reach the kidney; and the remarks that have been made to-night clearly illustrate this. One writer will prefer the lumbar incision another will select the abdominal method, while a third will use either plan, and yet in all the instances the disease may seem to be about as extensive and the size of the kidneys may be the same. A great deal depends upon the choice of the operator, as well as upon the condition and proportions of the patient.

The statistics of the removal of the kidneys for malignant disease are so unfavorable that any operation seems to be almost hopeless; nevertheless, I do not think, that in individual cases, this should be a contra-indication if the operation seems to be justifiable on other grounds. In children, the statistics of Dr. Gross, in 1885, were that in thirteen operations only four recovered from the operation, and these subsequently died from return of the disease elsewhere.

In operating in cases of wound of the kidney, it would seem to be guided by the position and extent of the wound. If the wound involves the abdominal viscera, no one would hesitate to open the abdomen. On the other hand, if there were any doubt, the course of the wound should be followed and the kidney reached and explored. If there are marked signs of hæmorrhage, the operation should be performed at once. Even if the hæmorrhage is retro-peritoneal, it may be assumed that, sooner or later, the clot will by pressure force its way through the peritoneum and cause septic peritonitis. Careful exploration and thorough drainage in these cases is absolutely requisite. In subparietal wounds of the kidney, if operation be necessary, it would seem that the

only choice is the lumbar incision. As illustrating the tolerance of the kidney for a certain degree of injury to its substance, a point to which Dr. Keen has called our attention, I may mention the following case: Some years ago I saw, at the Episcopal Hospital, a man who was brought in with a large hæmatoma of the back, the result of being struck in the loin by the buffer of a locomotive. He recovered without operation. A year later he returned to the hospital with symptoms of stone in the bladder. At the operation instead of a stone, there was found a spicule of bone, one-fourth of an inch wide, and one-half or three-fourths of an inch long. I assume that there had been a fracture of one of the lower ribs, a fragment of bone being driven into the kidney or its pelvis, and later finding its way into the bladder.

DR. HENRY F. FORMAD: I rise to protest against the rather loose pathological nomenclature in regard to malignant disease of the kidney. We hear of cancer of the kidney and of sarcoma of the kidney. Alveolar sarcoma and cancer are used synonymously. This is Virchow's view. According to modern views all of these things are sarcomas. Again, there is no such thing as epithelium in the kidney. There is only epithelium which cannot give rise to cancer.

It is a true mesoblastic growth which can only give rise to sarcoma. We can take for granted that all of these cases reported as cancers are sarcomata.

In sarcomata there are sometimes hæmorrhagic infarctions which give rise to indurated masses, and on section give to the growth the book appearance of cancer.

It is a well-established fact that tumors of the kidneys and of the suprarenal bodies will not encroach upon surrounding structures. They do not cause metastasis; so that removal of the diseased kidney to prevent the spread of the disease is unnecessary. In view of the bad statistical results, I think it would be better if these cases of malignant disease of the kidney were let alone.

I have a point to make in regard to floating kidney. I began to record the occurrence of floating kidney, having pretty good opportunity to do so. I was so successful that every day I found a floating kidney. I began to investigate and I found that every woman had a floating kidney. The right kidney of nearly every woman is so loosely attached that floating kidney on the right side is a normal condition in woman. Actual floating kidney is merely a question of degree. When you attempt to reach the right kidney in autopsies on women it is difficult to find it, as it is never in the same place. It never lies in close proximity with the liver as in man.

DR. WILLIAM J. TAYLOR: I had the pleasure of assisting at the operation of Dr. Keen and would emphasize the fact of the tremendous hæmorrhage, and also the extreme density of these calcareous masses. They felt exactly like a stone.

DR. JAMES TYSON: I would say a word with reference to the etiology of floating kidneys. I have had a number of such cases under observation. In searching for the cause, I have been compelled to conclude that in the majority of instances it is congenital, and what has been stated by Dr. Formad serves to strengthen this view. I have seen most typical instances of floating kidney in men, and I have seen it more frequently in women who have never borne children than in those who have had children. Even in those cases where it is supposed to have been caused by accident, I think that in all probability the condition has been congenital, and, if anything, only exaggerated by the fall.

In regard to the treatment of floating kidney by the use of pads, etc., I have had surgeons in consultation in cases of this kind, and I have never seen any advantage result from such devices.

DR. WILLIAM HUNT: I have recorded a case in which a fast kidney was found in the wrong place, which might confuse an operator cutting for the organ on account of symptoms. Some years ago, I made a post-mortem at the Pennsylvania hospital on a man who had died of concussion of the brain, in which I found the left kidney, enveloped in its capsule, lying upon the fourth and fifth lumbar vertebræ and partly covering the promontory of the sacrum. The sigmoid flexure passed along its outer and superior edges, while the rectum ran along the inner edge and from thence down the middle line of the sacrum. The emulgent vessels entered from above through a fissure in the kidney, leading diagonally from the superior edge to the pelvis.

The pelvis of the kidney and the ureter were normal, though of course the latter was shorter than usual. The sigmoid flexure embraced the kidney in its folds.

DR. J. M. BALDY: As regards the relative value of the lumbar and abdominal incision, the abdominal seems to me to present several points of advantage. Through the abdominal incision both kidneys can be reached with little difficulty. In all these troubles it is important that the second kidney should be examined, if the removal of one is contemplated. Where the lumbar incision is adopted this is, of course, impossible, and the difficulties of examining even the diseased kidney are well shown by the case under discussion. In the abdominal operation, the condition of the kidney could be determined, and just such accidents as happened in Dr. Keen's case—the stripping off of the capsule and the dangers of hæmorrhage and shock—would be averted.

There is great importance in drainage. A tube that can be kept clean, is the drainage tube *par excellence*—the glass tube is such.

In one case of malignant disease, in which I witnessed the removal of the kidney by the abdominal incision, the hæmorrhage not being entirely controlled, the peritoneal cavity was entirely closed off from the bed of the kidney by stitching the cut edges of the peritoneum together; prior to this, however, a counter-opening was made through the muscles of the back, and thus good drainage secured. Patient made a good recovery.

DR. JOHN B. ROBERTS: I wish to refer to a case of cure of movable kidney without operation. I had a boy, 7 years of age, referred to me four years ago by Dr. M. O'Hara. At irregular intervals the patient was seized with severe pain in the left side of the abdomen, and with this there was the appearance of a tumor in the hypochondrium and total suppression of urine. Various theories had been held to explain the condition. The only conclusion that I could reach, though this was not shared by Dr. O'Hara, was that the boy had a floating kidney, and that at the times of the paroxysms the ureters became twisted, causing the suppression of urine and the intense pain. The boy never had any pain or trouble with the urine except when the tumor was felt. At my suggestion Dr. O'Hara had made a pad which pressed against the left hypochondrium. This was worn for a short time. The boy then passed from my notice, but I learned a few days ago that he had perfectly recovered. There is, of course, in this case an element of uncertainty in regard to the diagnosis. When I looked into the literature of this subject, I was surprised to find how much stress was laid upon the possibility of the ureters becoming twisted, and the flow of urine being interfered with.

I wish, in connection with the question of the lumbar incision, to refer to an accident which I had in an attempt to explore the kidney for a supposed renal calculus. After making the incision down to the kidney, I determined to enlarge it a little. The diaphragm hung down in a fold and was readily seen. I made my incision a little longer in the upward direction, and made a minute perforation in the diaphragm where it is attached to the spinal column. There was a loud whistle as the air rushed into the pleura. I put in a suture and closed the opening, and no harm was done; but for a few days the patient insisted that the bandage was too tight, because he could not breathe freely. The pain which the patient had felt disappeared after the operation, although no stone was found. He went home before the wound had closed, and a number of months later died of some obscure disease.

It is important to recollect, when operating close to the vertebral column, that the posterior attachment of the diaphragm near the middle line extends further down than might be realized from watching its loose muscular curtain exposed in the wound.

DR. G. G. DAVIS: Dr. Formad seems to characterize all these growths as alveolar sarcoma. In primary growths of the kidney this may be correct, but such a statement gives one the idea that there is a sameness about these growths which is not the case. The tumor presented by Dr. Keen has the macroscopic appearance of scirrhus. In other specimens the growths may be smooth, resembling sarcoma found in other parts of the body. The macroscopic appearances of these tumors are decidedly different. When it is said that all growths of the kidney are alveolar sarcomata, I think that a mistake is made. Is not the kidney subject to secondary growths? We have an illustration of this in the case of Dr. Grove's. In his case, the first manifestations at least were in the axilla. In the report of the microscopical appearances, I did not hear the term alveolar sarcoma used. The disease of the kidney was what is commonly known as melanotic sarcoma. It was not supposed that the organ was the seat of a growth peculiar to the kidney.

DR. HENRY F. FORMAD: I did not mean to say that all tumors of the kidney were alveolar sarcomata. We have other forms of sarcoma, but what is commonly called cancer is alveolar sarcoma. Secondary growths of any character may occur, and even cancer may be secondary; but it will be only an insignificant part of the general disease.

DR. S. SOLIS-COHEN: The administration of morphia in these cases has been referred to. It is extremely dangerous to use morphia in any case in which the kidney has been treated surgically. I have seen several medical cases in which the use of morphia has produced suppression of urine. This point should be borne in mind by surgeons in the treatment of these cases.

DR. STEINBACH: I had expected criticism in regard to the diagnosis of my case, but nothing has been said on this point, and I therefore have little to reply to. Reference has been made to drainage. I was prepared to drain, but there was practically no hæmorrhage, and the whole procedure was perfectly clean, so that drainage was not required.

The dose of morphia given was very small, and was given without my personal knowledge. We have a house mixture containing small quantities of bromide and morphia. One dose of this was administered by the house physician. I do not use morphia after other surgical operations, and certainly would not use it in such cases as this unless strong indication existed.

DR. W. W. KEEN: I think that there is no doubt that in the case of a large tumor of the kidney, particularly a large solid tumor the size of which cannot be diminished by tapping, the position taken by several of the speakers is correct—that the anterior incision is the proper one. Where there is a small growth, or a stone in the

kidney, or the operation is an exploratory one, I cannot think that the anterior incision is the best. Statistics certainly show that the lumbar incision is attended with much less risks than the anterior. Where there is no reason to suppose that an unusual amount of room will be required, I think the lumbar incision is the proper one to employ.

It has been also suggested that possibly the anterior incision, in the present case of nephrectomy, would have given so much information that I should have decided not to operate. I do not think that I should have reached any such conclusion, for it was not the character of the growth, but the adhesions at the hilum that interfered with the removal of the organ, and these could not have been determined until the operation was in progress. I think that it would have been as impossible to remove the kidney by the one method as by the other. I had the pleasure of seeing Dr. Steinbach's case, but only for a moment just prior to the beginning of the operation, and I certainly was convinced that it was a case of enlarged gall-bladder with gall-stones. The slightest movement caused a grating of one stone upon the other. The tumor was in the position of the gall-bladder. I never before saw a kidney so displaced. The long axis, instead of being vertical, lay in an antero-posterior position, and the upper end of the kidney occupied precisely the position of the gall-bladder. The steps of the operation have been well described by Dr. Steinbach, and I have nothing to add. The mistake in diagnosis, under these circumstances, was very natural.

BOOK REVIEWS.

ELECTRICITY AND THE METHODS OF ITS EMPLOYMENT IN REMOVING SUPERFLUOUS HAIR AND OTHER FACIAL BLEMISHES. By PLYM. S. HAYES, A.M., M.D. Chicago: W. T. Keener.

The author has given the profession this little volume of 128 pages setting forth the subject in clear and concise language. In regard to the use of electrolysis in the removal of hair we learn that it has stood the test of not less than thirteen years and still stands as the most efficient means to be employed for this purpose. The book answers all possible inquiries that might arise in the mind of one interested in this subject, but still it does not hesitate to state that in no operation where human life is not involved does experience count for more than in this comparatively simple and easily executed procedure. We note that the author's ten years' experience in this use of electricity has taught him to anticipate the weakness of his fellow practitioner, whose mind is early reassured by the statement that he need know nothing of the theory of electrolysis, but that he must understand that the galvanic current is the only one to be employed. And finally, under the admonition of a series of "Dont's," he says: "Don't attempt to use the faradic current for electrolysis." Would anyone think of doing so who had at any time in his life read a work on elementary physics, such as is in daily use in the common schools. We certainly hope he would not; and yet, however much we dislike this intimation against the learning of the medical profession in a branch of elementary science, we must, nevertheless, bear it, for facts seem to justify it.

If all books which are written for a presumably scientific body, *i. e.*, the medical profession, were written in a thoroughly scientific manner, utterly ignoring the wants of the untutored, it would be infinitely better, not only for that profession, but for their literature. F. H. M.

HANDBOOK OF THE DIAGNOSIS AND TREATMENT OF THE DISEASES OF THE THROAT NOSE, AND AND NASO-PHARYNX. By CARL SEILER, M.D., Instructor in Laryngology and Lecturer on Diseases of the Upper Air Passages in the University of Pennsylvania, etc. Third Edition, thoroughly revised and greatly enlarged. With 2 lithographic plates containing 10 figures, and 101 wood engravings. 8vo, pp. xii—573. Philadelphia: Lea Brothers & Co. 1889. Chicago: A. C. McClurg & Co.

The author is a careful observer and a concise and accurate relator, and, rarer still in medical authorship, a master of the difficult art of omission The result is a handbook which will be read throughout with pleasure and profit by thousands, to whom the more exhaustive treatises are of service for occasional reference only.

Much space, proportionately, is devoted to the anatomy and physiology of the upper respiratory passages, and to laryngoscopic and rhinoscopic technique, including the various methods of electrical illumination. Preference is accorded to the electric incandescent light, which has been made available even to those not upon a regular light circuit, by the introduction of storage batteries, one of which, suitable for this purpose, is figured and described.

A new chapter on acoustics, voice production, and articulation, imparts a halo of originality to this part of the volume and is especially acceptable, inasmuch as the author is known to be one of few laryngologists qualified to discourse on this part of the subject.

No one section better illustrates the general character and scope of the work than that on "Hypertrophy of the Tonsils," in which three varieties are described, the ordinary soft tonsil of childhood; the scirrhous tonsil of young adults; and the so-called ragged tonsil. So much nonsense

has been informally promulgated concerning the operation of tonsillotomy that we quote the following passage from this authority: "The best and most satisfactory way of treating hypertrophied tonsils is to cut them off as close to the pillars of the fauces as possible," which calls to mind also a recent dictum by Mr. Lennox Browne, "Chronic enlargement of the tonsils is only to be treated satisfactorily by the one method of excision, and there does not appear any valid reason why there should be two opinions on the subject." This author recommends the tonsillotome for the soft tonsil and the cold-wire snare, to avoid hæmorrhage, for the scirrhous variety. Cautery-puncture is advised only for the ragged tonsil. Total extirpation or enucleation is both unnecessary and dangerous.

The ordinary forms of chronic pharyngitis such follicular pharyngitis and pharyngitis sicca are summarily dismissed as symptomatic expressions of pathological states elsewhere. It were better even as symptoms to give them more extended notice.

"Functional Disorders of the Larynx," "Laryngeal Neoplasms," "Atrophic Nasal Catarrh," and "Hay Fever," are intelligently summarized, while "Catching Cold," "Clergyman's Sore Throat," "Laryngitis Phthisica," "Chronic Nasal Catarrh," and "Tumors in the Nasal Cavities," are adequately treated and embody many original views and valuable suggestions.

W. E. C.

MISCELLANY.

THE MEDICAL SOCIETY OF NEW JERSEY will hold its next annual meeting in the Coleman House, at Asbury Park, on June 18 and 19, 1889, commencing at 4 P.M. of Tuesday, June 18. President, H. Genet Taylor, M.D., Camden; Secretary, William Pierson, M.D., Orange, N. J.

THE NORTH TEXAS MEDICAL ASSOCIATION will hold its next semi-annnal meeting in the city of Paris, Texas, beginning Tuesday, June 11, 1889, and continue its sessions for three days. The meeting will be called to order promptly at 3:30 o'clock, P.M. In addition to the subjects announced in the programme many interesting volunteer papers have been promised. It is requested that every one who may have a contribution for this meeting will upon his arrival promptly hand the title of his paper and his name to the Secretary, Dr. Geo. R. Clayton, so that it can be properly classified in its appropriate Section and come up in its regular order. The meeting in Paris promises to be one of the most attractive and successful the Association has ever enjoyed. Some distinguished visitorsare expected to be present.

LETTERS RECEIVED.

Dr. S. W. Williston, New Haven, Conn.; P. R. Cortelyou, Marietta, Ga.; Dr. L. Woodruff, Alton, O.; Dr. C. F. Barker, Newport, R. I.; Baker, Collins & Co., St. Paul, Minn.; J. W. Clarke, B. W. Smock, Louisville, Ky.; State Journal Co., Lincoln, Neb.; Dr. Chas. C. Browning, Adrian, Ill.; Dr. R. Harvey Reed, Mansfield, O.; Dr. F. Allport, Minneapolis, Minn.; Dr. W. M. Sprigg, Washington; Dr. L. W. Steinbach, Philadelphia; Miss Julia B. de Forest, Cold Spring Harbor, L. I.; Dr. H. Isaac Jones, San Francisco, Cal; Dr. Thos. W. Kay, Baltimore; M. E. Gaillard, New York; Dr. E. H. Pomeroy, Calumet, Mich.; Dr. H. J. Caldwell, Adel, Ia.; Dr. W. N. Simmons, Burlington, Vt.; Dr. C. O. Cooley, Madelia, Minn.; Dr. W. M. Moore, Paris, Tex.; Dr. F. Brother, St. Louis; Dr. H. Doe, Lyons, France; Dr. B. M. Ricketts, Cincinnati, O.; L. Hibbe, New York; Dr. Wm. B. Canfield, Baltimore; C. W. Franzoni, Washington; Dr. A. Parker Champlin, Ship Island, Miss.; B. Coryell, Chesaning, Mich.; W. P. Jones, Burlington, Vt.; Lambert Pharmacal Co., St. Louis; Frank, Kiernan & Co., New York; Dr. E. Chenery, Boston; Dr. A. R. Burton, Princeton, Ind.; Upjohn Pill and Granule Co., Kalamazoo, Mich.; Parke, Davis & Co., Detroit; Dr. L. S. McMurtry, Danville, Ky.; Dr. John M. Batten, Pittsburgh, Pa.; Dr. W. D. McCan, U. S. A., Fort Crawford, Col.; J. W. Parsons, Omaha, Neb.; J. H. Bates, New York; Dr. Louis A. Kengle, San Francisco; Dr. Geo. F. Cook, Oxford, O.; Dr. Jno. G. Ames, Palatka, Fla.; Long Island College Hospital, Brooklyn, N. Y.; P. V. Dolon, Washington; W. E. White, Burlington, Vt.; Dr. S. G. Webber, Jamaica Plain, Mass.; Fairchild Bros. & Foster, New York; Dr. M. A. Olive, Meridian, Tex.; Henry Liddell, Washington; Dr. Frederick E. Hyde, New York; Dr. Clark Gapen, Omaha, Neb.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from May 18, 1889, to May 24, 1889.

Major William H. Forwood, Surgeon, leave of absence granted on surgeon's certificate of disability, in S. O. 35, Dept. of Dakota, April 8, 1889, is extended one month on surgeon's certificate of disability, by direction of the acting Secretary of War. Par. 13, S. O. 118, A. G. O., Washington, May 22, 1889.

Major Passmore Middleton, Surgeon, will, as soon as practicable after his arrival at Ft. Trumbull, Conn., proceed to Ft. Warren, Mass., and report for temporary duty until the return of the post surgeon from detached service with batteries of the Fourth Artillery ordered to Atlanta, Ga. He will then return to his proper station (St. Francis Bks., Fla.). Par. 2, S. O. 113, Hdqrs. Div. of the Atlantic, Governor's Island, New York City, May 18, 1889.

Capt. Aaron H. Appel, Asst. Surgeon, leave of absence granted in S. O. 38, Div. of the Missouri, April 16, 1889, is extended twenty days, by direction of the Secretary of War. Par. 2, S. O. 114, A. G. O., Washington, May 17, 1889.

Capt. William Stephenson, Asst. Surgeon, granted leave of absence for four months, with permission to go beyond sea, by direction of the Secretary of War. Par. 15, S. O. 114, A. G. O., Washington, May 17, 1889.

First Lieut. Ogden Rafferty, Asst. Surgeon, granted leave of absence for one month. Par. 3, S. O. 29, Hdqrs. Dept. of Texas, San Antonio, Tex., May 13, 1889.

Official List of Changes in the Medical Corps of the U. S. Navy for the Week Ending May 25, 1889.

P. A. Surgeon L. G. Heneberger, detached from the "Thetis" and ordered to the "Iroquois."

Asst. Surgeon F. A. Hesler, promoted to be Passed Assistant Surgeon in the U. S. Navy.

CORRIGENDA.

In the report of Dr. Wm. H. Welch's paper on "Hydrophobia," published in THE JOURNAL of May 18, occur the following errors: Page 691, col. 1, line 23 from top, read Zagari, instead of Lagari; p. 691, col. 1, line 21 from bottom, read milk, instead of neck; p. 691, col. 1, line 15 from bottom, read nerves, instead of nerve; p. 691, col. 1, line 13 from bottom, insert *only*. after multiplication; p. 692, col. 2, line 15 from top should read, "Dr. Welch collected from Pasteur's reports for 1887 and the first half of 1888," etc.